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Santé et Bien-être social Canada

Background Paper on Women and Tobacco (1987) and Update (1990)

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BACKGROUND PAPER ON WOMEN AND TOBACCO (1987) AND UPDATE (1990)

Prepared for the

HEALTH PROMOTION DIRECTORATE
HEALTH AND WELFARE CANADA
AND THE
NATIONAL WORKING GROUP ON WOMEN AND TOBACCO

by

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The views expressed herein are solely those of the author and do not necessarily represent the official policy of Health and Welfare Canada

Background Paper on Women and Tobacco (1987) and Update (1990)

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PREFACE

The *Background Paper on Women and Tobacco* was first published in November, 1987. Since its launch at the National Workshop on Women and Tobacco in March, 1988, awareness of the complex issues surrounding women's tobacco use has risen dramatically. This second printing leaves the original Background Paper intact, but includes a update discussing new trends and issues for future action on women and tobacco.

Lorraine Greaves
November, 1990

BACKGROUND PAPER ON WOMEN AND TOBACCO

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1990 UPDATE TO THE SECOND PRINTING

In the three years since the *Background Paper on Women and Tobacco* was originally published in late 1987, the issue of women and tobacco has gained some long overdue attention in Canada. There is a growing understanding and awareness of the issues confronting women, women smokers and women attempting to curb their use of tobacco. While much is left to do, more and more initiatives are being taken to create resources and programs directed toward the prevention and cessation of tobacco use among women and girls.

The National Workshop on Women and Tobacco sponsored by Health and Welfare Canada on International Women's Day, (March 8) 1988, marked the integration of efforts of both the women's health movement and the tobacco control movement in Canada. The Proceedings of this Workshop (1) reflect initial attempts to integrate goals and share understanding in the interest of improving Canadian women's health.

Those in the women's health movement learned that smoking is a crucially important behaviour to address, and a serious impediment to women's empowerment. Those in the tobacco control movement learned that women's smoking is linked to women's experience of inequality and cannot be productively addressed outside of that context.

Since then, the profile of the issue of women's smoking has remained high. The Canadian Council on Smoking and Health published *Taking Control: An Action Handbook on Women and Tobacco* (2), the Eastern Ontario Health Unit organized an international conference on teenage girls' smoking, called Roses or Ashes?, and Health and Welfare Canada is supporting a project to develop a video on the issue of teen girls' smoking. In addition, several innovative prevention and cessation projects in various regions have been initiated.

The international tobacco control movement, at its 7th World Conference on Tobacco and Health (April, 1990) in Perth, Australia, saw the emergence of the International Network of Women Against Tobacco (INWAT). This group is devoted to linking individuals, groups and agencies interested in gender, class and Third World tobacco use issues. There is growing pressure to create a gender-sensitive global tobacco control movement, including increasing the involvement of women in international conferences.

In the midst of these positive trends, however, are some indications that the smoking behaviour of girls and women in Canada is not improving quickly enough, and, as we move into the 1990s, is becoming more problematic than ever. Smoking is still the leading killer of women in Canada, with upwards of 15 000 women dying yearly from smoking-related disease (3). Clearly, there remains a need for continued vigilance and increased creativity on the part of government and tobacco control advocates in dealing with this significant women's health issue.

Trends in Tobacco Use

**Lower rate of decline among women*

Overall, tobacco use in Canada is declining. However, a significant and troublesome pattern associated with women's tobacco use in Canada (and many other developed countries), is the *low rate of decline* in consumption among women over the past two decades, particularly when compared to the much high rate of decline among men (See Figure 1).

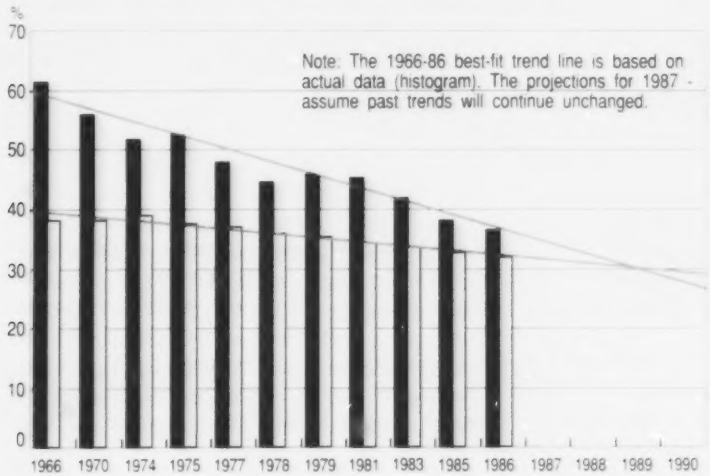
The proportion of cigarette smokers who are female has slowly risen over the past two decades. Worse, over the past three years in Canada, the prevalence of smoking among women has stalled at around 30 percent, showing no overall decline at all (4).

This lower rate of decline has caused health educators, researchers and others a great deal of concern, resulting in more attention being paid to aspects of women's experience and smoking behaviour that may help to explain this. This attention has resulted in the development of some women-specific programs and resources, and a slowly increasing gender sensitivity in research on smoking.

**Higher rate of smoking among young women than young men*

In addition to this lower rate of decline among female smokers generally, teenage girls and young women (age 15 to 24) are smoking at higher rates than their

Figure 1
Current Cigarette Smokers, 1966-1986 and Projections, 1987 -


%
70
60
50
40
30
20
10
0
Note: The 1966-86 best-fit trend line is based on actual data (histogram). The projections for 1987 - assume past trends will continue unchanged.
1966 1970 1974 1975 1977 1978 1979 1981 1983 1985 1986 1987 1988 1989 1990
LFS, age 16+ (adjusted for proxy error)

male counterparts. This is an alarming first-time trend in Canada that demands our immediate attention. (In 1989, about 31 percent of 15 to 24 year old women used tobacco daily, compared to 30 percent of young men. (4))

Almost 38 percent of young women aged 20 to 24 are smoking, slightly higher than men of the same age, and more than any other age group of women or men in Canada (4).

*Rates of smoking among older women increasing

Should today's young women continue to smoke, then women will experience high smoking rates than men across the higher age groups in future decades. Already, women's smoking rates among those 35 and over are increasing, as younger women smokers age. (For example, over the last three years, the smoking rates for women aged 55 to 64 have gone up from 25 percent to 29 percent (4)).

All of these trends will bring the delayed health effects and increased death rates caused by tobacco smoking to increasing numbers of Canadian women. Without immediate and effective intervention, the health and social costs associated with women's smoking will become more pronounced in Canada's future.

How Do We Explain These Trends?

Why are these trends in girls and women's smoking persisting? Why are young women and teenage girls in Canada now smoking at higher rates than their male counterparts? This pattern is perplexing to many in the tobacco control movement, after 20 years of active anti-smoking education and prevention work in Canada.

Several questions emerge in pursuing the answer. Have prevention and cessation efforts been less effective on females than on males? Is there something about the female smoker or smoker-to-be that is not yet fully understood? Is the experience of growing up female a factor in smoking initiation and maintenance? Have tobacco advertising and marketing campaigns directed at females simply been extremely effective?

Much of the research, prevention and cessation effort has been "generic" in approaching the issue of smoking, (which, as in most fields, has often meant male-oriented or gender-neutral in its orientation). It is only very recently, coinciding with the growth of a stronger women's health movement in Canada, that programs of research, prevention and treatment are increasingly gender-sensitive in their approach. While much remains to be understood about the reasons why girls and women begin and continue to smoke, what smoking means to girls and women (5), and how best to change these behaviours, some efforts are underway in Canada to develop understanding in this area.

The development of young girls' identity has been virtually ignored in the general literature on adolescent psychology (6). Consequently, little is yet known about the major psychological development issues common to girls growing up in the 1990s. However, issues concerning self-esteem, sexuality, body image and career aspirations and expectations are all deemed important to understanding the development of identity in girls.

How these issues connect to smoking decisions and behaviour must still be fully determined. In addition, how young girls deal with the *expectation* of social equality in the face of their *observation* of ongoing inequality for women is another open question. Due to their higher expectations, issues such as women's double daily workload, pay inequity, and inaccessible child care may serve to frustrate girls and young women even more in 1990 than 20 years ago.

Health Costs

Approximately 15 000 women die in Canada every year of tobacco-related causes. This means that every 35 minutes a woman dies a preventable death due to smoking. The costs of smoking to women's health have been increasingly well-documented in recent years. It has become no longer sufficient to assume that conclusions about male subjects will apply equally to female subjects, or that "generic" prevention and cessation programs will necessarily suffice in controlling women's smoking.

However, it is likely that we still do not know the full extent to which smoking affects women's bodies and women's health. Recent research, for example, has highlighted the association between smoking and cervical cancer (7). Nicotine, one of the active ingredients in cigarettes, is observable in the cervical cells of women smokers (8). Cervical cancer has joined the list of smoking-related diseases, which include coronary heart disease and stroke, the most frequent smoking-related disease, and lung cancer and other respiratory diseases. Other woman-specific health effects of smoking include several reproductive-related diseases and conditions, including menstrual disorders, early menopause, osteoporosis, and several risks to pregnancy and fetal health (9).

Global Trends, Global Issues

Globally, the size of the smoking epidemic is growing faster than the world population (10). However, not all countries in the world have, as yet, experienced growth in female smoking rates. Similarly, not all countries have seen young boys' rates overtaken by young girls' rates. While there is no consistent pattern, the increased young women's smoking rate appears to be a phenomenon in several developed, industrialized countries (see Figure 2) (11). Meanwhile, many less industrialized countries experience a lower rate of female smoking, while male smoking is still an increasing problem.

■ Figure 2
Countries Where More Girls Than Boys Smoke

	Girls	Boys	Age
Chile (1979)	59	57	15–20
New Zealand (1985)	45	27	15
France (1984)	42	37	12–18
Fed. Rep. Germany (1984)	31	24	14–19
U.S.A. (1987)	31	27	15–18
Australia (1987)	30	27	16
Wales (1988)	24	16	15–16
Scotland (1986)	26	24	15
Denmark (1987)	25	22	15–19
Iceland (1986)	24	20	15–16
Norway (1986)	24	20	15
England and Wales (1988)	22	17	15
Canada (1986)	21	21	15–19
Austria (1986)	20	18	15
Sweden (1986)	17	14	15
Switzerland (1986)	15	13	15

Overall, the popularity of smoking is shifting from the more to the less developed countries. In the developed countries, increased health education, government intervention, advertising bans, and increased taxation all contribute to reduced consumption of tobacco.

However, in some developing countries, where health education and government regulations are either non-existent or poorly developed, smoking is becoming more widespread. This trend is being actively cultivated by transnational tobacco companies who are targeting such markets to compensate for declining markets in the developed world. Aggressive, well-targeted campaigns are focussed on various sectors of the global population, including girls and women.

The issues involved in transferring the marketing and production of tobacco to developing countries include poverty and nutrition issues, environmental concerns, and the exploitation of various class, gender and racial groups. In countries where tobacco growing and/or the production of cigarettes has been introduced by the transnational tobacco companies, the local economies become unbalanced.

Sometimes this leads to the elimination of local food-growing, necessitating the importation of foods, and making them available only to those with cash. As cigarette smoking becomes more habitual, more cash is needed. Sometimes, the money necessary to support an ongoing addiction to cigarettes comes directly from the family food budget. Even when the smoking habit is popular only among a country's men, women and children suffer directly due to lost resources.

The production of cigarettes also consumes resources such as land, trees and space. It is estimated that approximately one tree is burned to fuel flue-curing for every 300 cigarettes produced (12). Such forest devastation, and other environmental concerns, such as pesticide use in tobacco cultivation, the effects of secondary smoke, and indoor air pollution has raised the interest of environmentalists in tobacco control.

Similarly, international development workers have concerns about seeding cigarette addiction among populations vulnerable to marketing and promotion, without the backdrop of widespread health care and information. The strain on developing health care systems only increases as smoking-related diseases begin to develop in populations new to the tobacco habit. In countries struggling to provide basic health care to women and children, dealing with the effects of tobacco is an unwelcome burden. Many of these countries are looking to countries like Canada for advice in dealing with the issues of children, women and tobacco.

Canadian Trends, Canadian Issues

Within a developed country like Canada, smoking has shifted in popularity from the advantaged to the disadvantaged. The economic and health implications of tobacco use for such groups are different, and possibly more serious, than those for more privileged Canadians. Disadvantaged groups, whether low-income or oppressed minorities, have fewer resources with which to either support or combat tobacco addiction.

For low-income Canadians, the costs associated with tobacco use are less easily met. At current cigarette prices, the one-pack a day smoker must spend almost $2 000 per year on cigarettes. While the official poverty line is difficult to determine, it is estimated that a single Canadian needs between $9 500 (in rural areas) and $14 000 (in large cities) yearly income to live (13). Consequently, 14 to 20 percent of annual income must be devoted to cigarette purchases. Analyses of tobacco spending for low-income Britons, using 1986 figures, indicated approximately 9 percent of family income went to cigarette purchases (14).

To what extent this affects other parts of Canadian family budgets is not yet clear. However, British research on low-income people indicates that food spending is the most elastic part of the family budget. In addition, cigarettes come to be viewed as one of the essential, fixed costs, along with fuel and housing (14).

But most crucial is the attachment many low-income women smokers have to cigarette purchases. They represent one of the few purchases directed solely toward their own pleasure, and one of the few luxuries in their lives. A comprehensive assessment of Canadian low-income women smokers may reveal similar patterns. As is true in developing countries, family food budgets may absorb the cost of cigarettes.

We do not know to what extent men or women smokers make different spending decisions. In general, however, men have higher incomes in Canada, and within families, may have more control of the overall budget. It may be that women's control of the family food budget allows tobacco purchases to be made most easily by reducing the expenditure on food. The health costs of smoking for low-income women and their families are compounded by possible nutritional deficiencies and related illness.

As taxation increases the cost of cigarettes in Canada, such spending decisions, particularly for low-income women, become more difficult. The links between increased use of food banks by women and children, smoking, and taxation need investigation in the Canadian content.

Another issue of concern to Canadians is the ongoing sponsorships of sports and culture by cigarette companies, an area not covered by the Tobacco Products Control Act passed into federal law in 1988 (15). Companies are allowed to use their company names, but not the names of the cigarettes, in sponsoring events. Equestrian events, women's golf, women's tennis, auto racing, ballet and other activities continue to be sponsored in this way.

Despite the passage of legislation controlling tobacco advertising in Canadian magazines, tobacco companies still manage to promote cigarette smoking through movies and fashion ads. Ads showing models smoking cigarettes imply a sexy, sophisticated attitude (16). Tobacco companies now pay to have movie actors and actresses smoking their brand of cigarettes (17). In addition, foreign magazines, particularly American women's magazines, still enter Canada containing tobacco advertising that can have a profound effect on Canada's girls and women.

Shifting Our Perspective

In general, the approach to understanding the issue of cigarette smoking is being widened from a strictly medical and health perspective, to include a socio-political perspective. Consequently, smoking is of concern to a wider and wider range of activists, professionals, and agencies working to improve, not only health, but also socioeconomic status, community and individual empowerment, and the overall reduction of inequities in health. Increased blending of "health" reforms with "welfare" reforms is necessary to fully address the newest trends in smoking.

This approach is in keeping with the Health and Welfare Canada document, *Achieving Health For All*, authorized by Jake Epp, former Minister of Health, in 1986 (18), and with the World Health Organization's thrust toward "Health For All" by the year 2000.

The National Strategy to Reduce Tobacco Use (NSRTU), launched in 1985, is designed to address all aspects of the tobacco issue (health, political, social, economic and scientific). Bringing together federal, provincial, and territorial governments as well as eight national health organizations, the Strategy is based on the belief that the impact of efforts to reduce tobacco use in greater if all organizations collaborate on activities in a complementary way.

One of the first attempts to come to grips with the breadth and complexity of the tobacco issue was made in the Directional Paper of the NSRTU. This landmark document provides a framework comprising goals, quantifiable objectives and strategic directions aimed at facilitating co-ordinated planning and program development. In the five years since the Strategy's inception, major projects have been launched and the public is becoming increasingly interested in, and vocal on tobacco issues.

Each year, the Steering Committee of NSRTU sets priorities for action which reflect the concerns of member organizations. Currently, priority has been placed on such areas as legislation to restrict access to tobacco by minors, availability of teen cessation programs, and prevention programs for young women.

In the short history of the Strategy, it is evident that the most promising way of curbing tobacco consumption is to adopt tobacco policies that co-ordinate a range of collective and individual measures at the community, regional and national levels. The type of widespread, long-term change that is required will come about only through a collaborative, comprehensive, and co-ordinated effort – the kind of effort for which the Strategy is striving.

It is fair to say that Canada is among the most progressive countries in tobacco control. Not only has strong legislation been passed to control smoking, tobacco advertising and promotion (The Tobacco Products Control Act and the Non-Smokers Health Act) but initial efforts are also being made to collaborate with community, cultural and women's groups to approach tobacco control in its wider, social context.

Both legislative and policy formation are necessary. But blending more sensitivity to the plight of the individual smoker into programs designed to lower consumption is imperative. Taxation increases, for example, which effective in reducing overall consumption, and therefore of benefit to women's health overall, are also regressive and punitive to individual women smokers, who are often on a low income to begin with. Only be increasing attention and commitment to providing well-funded cessation assistance to smokers, can the regressive aspect of such broadly based strategies be softened.

Actions in Canada

Several projects are under way in Canada developing prevention and cessation programs for girls and women. The move toward specialization in tobacco programming is intended to provide more relevant and effective materials and experiences for women and girls. Further specialization in program development will undoubtedly occur, to make materials relevant to an increasing diversity of women and girls, such as those

in all racial, ethnic, educational and linguistic groups, of any region, age, ability or sexual orientation.

Developing female-specific programs in prevention and cessation is necessary. Given the statistical trends and patterns of women's tobacco consumption, gender differences in the physiology and social psychology of smoking, women's particular experience of inequality, and strong woman-centred advertising and promotion by the tobacco companies, it is crucial. After all, if companies have successfully targeted women and girls as tobacco consumers, prevention and cessation efforts must do the same (20).

Three years ago, there were very few programs and little evaluation of a gender-specific approach in Canada. Since then, considerable activity has occurred to reduce girls and women's smoking. Although still too early to have complete evaluations, three projects supported by Health and Welfare Canada (in Saskatoon, Regina and Winnipeg), offer some interesting ideas for future nationwide programming. Programs in Quebec, Ontario, and Prince Edward Island offer additional ideas about innovative programming for girls and women.

1) ***Take Control***, Saskatoon Community Health Unit, Saskatoon, Saskatchewan

   This program is a 16-week group program for women, focussing on developing an holistic understanding of taking control of one's health and life, and some insight into smoking behaviour. The participants, a mixed group of women, responded to newspaper advertisements in Saskatoon. A control group of women smokers is also being followed, and the evaluation of a revised program is underway. The materials produced for this program include a participants' manual, a guide for facilitators and a resource book.

2) ***The Pregnant Women and Tobacco Smoking Cessation/Reduction Project***, Balfour Tutorial Program and the Regina General Hospital, Regina, Saskatchewan

   This project was designed for young, pregnant, mostly native, teenage smokers. Designing the intervention was largely left to the young pregnant women and new mothers themselves. Several tools were developed by the participants themselves, including a video on prenatal care, *The Best For Baby and You*, made with the help of the Saskatchewan Indian Federated College (Students), a weekly self-help cessation group for pregnant teens, and a Smokefree Home project. The video has been copied and distributed to 20 reserves in Saskatchewan, and is under evaluation.

3) ***Catching Our Breath***, A Journal About Change For Women Who Smoke, Women's Health Clinic, Winnipeg, Manitoba

   This 136-page, spiral-bound journal can be used by women alone, or in self-help or facilitated groups. It encourages women to read and write material on health improvement, relaxation, and personal growth, before addressing quitting and relapse issues. Available with a facilitators' guide, this journal is intended to support women in the journey toward better health. Emphasis is placed on examining social and political forces that may contribute to women's smoking.

4) ***Oui, j'arrête***, A cessation program for functionally illiterate women, Département de santé communautaire, Hôpital général de Montréal, Montréal, Québec

   In Montreal, the cessation program *Oui, j'arrête* is under development for functionally illiterate women. So far, the materials for this program are available in French only, but may be translated when funding allows. These pictorial materials offer assistance and tips to modify women's smoking behaviour using a self-reward system. Insight into smoking behaviour is gained through the materials and group discussions. While the cessation rate is low, and the drop-off rate high thus far, the program is continuing to revise and refine its materials. This project has been funded by Health and Welfare Canada through a research grant, and by the Regional Council of Health and Social Services of Montreal.

5) ***Project Vogue***, Eastern Ontario Health Unit, Cornwall, Ontario

   This project stresses both prevention and cessation among teenage girls in secondary school physical education classes. The prevention aspect is contained in a curriculum offered to girls by their physical education teachers. The cessation component is a series of eight, facilitator-led voluntary

group meetings for girls wishing to quit smoking. About half of the 19 high schools in five counties in Eastern Ontario participated in the program, with two schools serving as controls. Both parts of the program are to be repeated and evaluated during 1990-91, to revise the program and establish its usefulness. This project was jointly funded by the Ontario Ministry of Health and the Health Promotion Contributions Program, Health Promotion Directorate, Health and Welfare Canada.

6) ***Lib-Air-Té***, Eastern Ontario Health Unit, Hawkesbury, Ontario

This cessation program for women uses computer-assisted smoking treatment (C.A.S.T.). The Life Sign computer was used, supported by group sessions. The participants, drawn mainly from workplaces through advertising, paid a small fee for the computer device. Of the 97 women enrolled, many reduced their consumption, and 32 percent quit entirely by the end of the program. At a nine-month's follow-up, 23 percent of the women were still not smoking. Many of the women involved in the Lib-Air-Té were under 40 and Francophone. The quit rates were highest among the participants with higher socioeconomic status. This project was funded by Health and Welfare Canada.

7) ***Smoking Cessation Project***, Algoma Interagency on Smoking and Health, Sault-Ste-Marie, Ontario

This multimedia project has four components, some of which are specifically directed toward women and girls aged 13 to 40. A poster and a set of pamphlets on women and smoking were developed and distributed. A tear-off "prescription pad" listing all available cessation resources was distributed to all doctors' offices. A sticker campaign for stores to deter sales to children was developed. Under development is the fourth phase, designed to target 13 to 25 year-old girls and women. This project, funded by the Ontario Ministry of Health, will be evaluated in 1991.

8) ***The Women and Smoking Self-Help Group***, Self-Help Clearinghouse of Metro Toronto, Toronto, Ontario

This project, funded by Health and Welfare Canada, attempted to develop self-help groups and mutual aid methods for women smokers and ex-smokers. Although over 110 people telephoned in response to advertising (by mail, flyer, media), and community outreach, only 15 women actually attended self-help groups. The groups that did develop were unstructured and leaderless by the choice of the participants. The initiative for the groups came from the clearinghouse and not the women smokers themselves, which may have affected the development of the groups. This project did establish that there is a generalized need for smokers' support groups where cessation is not necessarily the goal.

9) ***Born Free***, Prince Edward Island Health and Social Services, Division of Nursing,

This project, based on the Lung Association "Smoke-Free for You and Your Baby" program, identifies pregnant smokers at their first medical checkup. A support system for cessation, including the doctor and the public health nurse, is offered to the pregnant woman. The women who choose to participate pay a small amount for a manual, watch a video and receive home visits from a public health nurse. Many of the pregnant women cut down consumption, and approximately 25 percent quit entirely. A longer term follow-up is being developed. This project is financed through the regular budget of the Division of Nursing.

10) ***Nurses and Smoking Project***, Prince Edward Island Council on Smoking and Health

This multi-faceted project involved research on the smoking behaviour of P.E.I. nurses, and the development of resource materials for the nursing school curriculum and for hospital and student nurses' cessation. An important goal of the project was to reduce the incidence of student nurses initiating smoking while in nursing school. An evaluation of the use of the nursing school curriculum module will take place in 1991. The cessation kit developed in this program resulted in a 23 percent quit rate among hospital nurses. The research for this project utilized the Canadian Nurses Association national nurses' tobacco survey questionnaire. This project was funded by Health Promotion, Health and Welfare Canada.

11) ***Community Smoking Cessation Programme for Low-Income Women***, South-East Ottawa Community Resource Centre, South Riverdale Community Health Centre (Toronto), and the North Kingston Community Health Centre, Kingston, Ontario

    This jointly developed project is a two-phase program, consisting of two six-session courses. The first six-group sessions are designed to assist low-income women smokers in developing enough motivation and confidence to quit. The second phase is for those women who have decided to quit. This section of the project includes information on techniques, as well as group and buddy support. These courses are free, and include child care and transportation costs, increasing their accessibility. After the pilot projects, overall evaluation of the group's effectiveness will commence.

An additional initiative under way at Health and Welfare Canada is the development of a video on girls' tobacco use. This is congruent with suggestions from the Background Paper on Women and Tobacco, and Smoke Screens, a 1988 report (21) recommending an overall audio-visual approach for women and tobacco. This video will be ready in 1991, and will focus on young girls' experience and choices with respect to smoking. Similar resources for adult women may be developed in the future.

Global Actions

Although the World Health Organization estimates only 5 percent of women smoke in developing countries, the evidence indicates that the pattern of the smoking epidemic in developed countries is likely to be replicated (22). Across the glove, sexist, racist and classist advertising is increasing, in order to attract new smokers. Secret marketing documents of R.J. Reynolds "Dakota" campaign in the United States revealed a carefully constructed marketing strategy aimed at young blue-collar women. Uptown cigarettes were recently marketed exclusively to Afro-Americans, and marketing strategies place more tobacco advertising in black neighbourhoods than in white neighbourhoods in the U.S. (23).

Advertising in such countries as India (the Ms. cigarette campaign) and Hong King (Virginia Slims) portrays and idealizes Western cultural values, using themes familiar to the developed world. Cigarettes are being portrayed as powerful, elegant and liberating, in the clear hope of developing brand new markets, particularly among women and girls. Countering these activities, the governments and health educators of developing countries are looking to our experience to learn effective interventions.

At the Seventh World Conference on Tobacco and Health, held in Perth, Australia in 1990, a pre-conference workshop was held on Women and Tobacco, chaired by Dr. Bobbie Jacobson of England. Representatives from many countries, including Canada, used the backdrop of worldwide smoking prevalence trends to make recommendations to the tobacco control movement on ways to address women's tobacco use.

The International Network of Women Against Tobacco (INWAT) was established at the conference in Perth, and is organized through the American Public Health Association. A Canadian section of this network is being organized through the Heart and Stroke Foundation of Ontario. This organization is dedicated to countering the targeting of tobacco marketing and promotion to women and girls, and to developing women-centred prevention and cessation.

Attention is also being paid to developing adequate representation of women and the awareness of gender issues in meetings, organizations and publications concerned with tobacco and health. INWAT is represented on the organizing committee of the Eighth World Conference on Tobacco and Health, to be held in Argentina in 1992.

The Next Steps

It has been estimated that the annual global death rate for smoking will rise from the current 2.5 million to about 12 million by the year 2050 (24). A significant number of these deaths will be women, and an increasing proportion will be among the least advantaged sections of Canada's population, and in developing countries.

Tobacco use, both within Canada and across the globe, is shifting from the domain of the privileged to the less privileged. Consequently, race, gender and class are becoming more and more the determinants of tobacco consumption, both here and abroad. Extremely high rates of smoking in native groups, both female and

male, and among the unemployed are two Canadian illustrations of this trend.

Parallel to this shift is the transfer of tobacco cultivation and cigarette production to new locations in the developing world. As progressive, developed countries such as ours create a less hospitable environment for tobacco manufacturers and marketers, we must also take some responsibility for shifting or exporting the problem of tobacco to those less able to cope with it.

While tobacco consumption declines in Canada, the questions underlying the issue of girls' and women's consumption of tobacco remain difficult and perplexing. Only continued collaboration and action, involving all sectors of the Canadian and global tobacco control movement, and all sectors of the world-wide women's health movement, will help to solve this problem.

Future Programming Needs In Women And Tobacco

Some future programming needs in the area of women and tobacco use are emerging in Canada. While some of these recommendations are similar to those in the body of *The Background Paper on Women and Tobacco*, written in 1987, they are still pertinent today. Others of these recommendations have merged in the last three years.

Research

1. There needs to be continued and increased emphasis by funders on requesting gender-sensitive research.

2. There needs to be increased use of qualitative methodology, in conjunction with quantitative methodology, to more fully enable us to understand women's smoking behaviour.

3. Survey data are needed on the smoking behaviour of several special populations. These include ethnic and racial groups, immigrant women, women victims of violence, native women, women with disabilities, women in prison, lesbians, illiterate women, certain female-dominated occupational groups, and children.

4. Existing research funds and projects should be reviewed for sexist bias (in research focus, approach, methodology, dissemination of funds, etc.), particularly in the areas of research on diseases associated with smoking.

Prevention

1. Immediate study of the social and psychological development of teenage girls is needed, in order to design more effective prevention materials.

2. The development of specific materials for the special populations mentioned above may be more effective than generic materials. Such materials must be developed in conjunction with the targeted groups.

3. A project reviewing existing prevention and cessation materials, examining them for sexist bias and inappropriateness, and updating them, is needed.

4. A pamphlet discussing why smoking is a women's issue, developed for nation-wide use, would be a useful resource for many groups in both the women's movement and the tobacco control movement.

5. Further encouragement of "smoke-free home" and "smoke-free car" campaigns would raise more awareness of passive smoking issues, and protect children's and non-smokers' health.

Cessation

1. Continued development and evaluation of specialized cessation programs for various populations of women and girls in Canada is necessary.

2. Research and development of knowledge on "self-quitters" is urgently required to better inform cessation efforts.

3. A native-controlled and defined program of tobacco control (prevention, cessation, research and policy development) needs to be encouraged with financial support.

4. A project directed toward developing cessation programming for older women/long-time smokers is required.

Policy and Legislation

1. Tobacco control (and taxation) policies must be developed in conjunction with overall social welfare policies. Ensuring that tobacco policy is "feminized" (25), and integrated with social welfare and anti-poverty policy will be increasingly necessary in Canada.

2. A national network on women and tobacco needs to be established, to co-ordinate information, activity and policy development in Canada. In addition, such a body would co-ordinate with the International Network of Women and Tobacco.

3. Prevention and cessation programs and policy measures should de-emphasize the individual smoker's behaviour, and stress social measures that will reduce or prevent smoking behaviour.

Although much has been accomplished in the past three years, both in Canada and globally, to increase understanding and control of women's smoking, much remains to be done. While overall declines in rates of smoking among Canadians are welcome, difficult questions and disturbing trends in girls' and women's smoking need immediate and concerted research and programming attention.

As we progress, it will become necessary to further specialize our knowledge and experience, by paying particular attention to various subpopulations of women and girls. Only continued collaborative and co-operative efforts between all sectors will ensure such progress. In addition, as we enter the 1990s, Canada must play a leading and responsible role in the global efforts to reduce tobacco use, particularly among the world's women.

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Executive Summary

It is well established in Canada that people's health varies according to their economic circumstances. This inequity is due to differences in knowledge, access, and life experiences that either promote or detract from good health. As women suffer more from inequality than men in Canada, both economically and socially, they constitute a special group for health planning.

Tobacco use in Canada continues to be a significant health problem, causing death and disease to thousands of Canadians each year. Smoking behaviour, as a major preventable cause of considerable human and economic pain, is a focus for much research, education, and treatment programming. Improving our understanding of women's use of tobacco, the focus of this background paper, poses a double challenge, requiring that both the health and gender inequities in Canadian society be addressed.

To combat women's use of tobacco, and the significant interest teenage girls show in cigarette smoking, it is necessary to regard women's experience in Canadian life as different than that of men. Further, it is necessary to regard various sub-populations of women, such as native women, young women, poor women, or working women, as different from each other. Refining and focussing our view of women's smoking behaviour, as well as understanding that women have a unique life experience, allows us to create and plan more effective research, education and treatment programs in the effort to reduce women's consumption of tobacco.

The initiation of smoking behaviour in girls and women is heavily influenced by social pressures and psychological needs. The advertising and promotion of tobacco, using themes of sexual attractiveness and freedom, is particularly effective on teenage girls. The availability of tobacco, smoking maternal role models, and pro-smoking friends and environments create opportunities for the initiation of smoking in females.

Women continue to smoke to feed the quickly developed physiological dependence, to prevent weight gain, and to relieve the stress that most women today experience. Certain groups of women, particularly the doubly disadvantaged (i.e. native women, poor women, battered women, and unemployed women) experience higher smoking rates than others, an indication of the inequalities of those positions in the structure of Canadian life.

Many women want to quit smoking, but experience difficulty in doing so. Many make repeated attempts to quit, and more women than men attend cessation programs. Although women appear to have no more difficulty in quitting than men, cessation attempts are hindered by the continuing deleterious effects of social and economic inequality. The stress of both paid and unpaid work, the large responsibility for child care, and the poor position in the occupational structure all create ongoing pressures for women that detract from efforts to "take control" of their health behaviours.

In addition, cessation materials and programs are often not designed specifically with women in mind, and therefore may be inaccessible or inappropriate for many groups of women.

The current response to the issue of women's smoking in Canada is incomplete and without direction. The National Program to Reduce Tobacco Use, and the National Working Group on Women and Tobacco, is working to co-ordinate a well planned strategy on this important women's health issue. The linking of the women's health movement to the existing resources of all the concerned agents in health, government, and disease control organizations is seen as vital to the development of an effective plan. This background paper is designed to initiate debate and discussion that will result in a creative, forward-looking strategy to reduce tobacco use among women in Canada. Aspects of the smoking literature and an assessment of the current response in Canada are integrated to provoke and inspire interest and activity in this issue.

Plans to improve the response to the problem of women and smoking include short term and long term measures. As well as segregating women out for particular attention in tobacco reduction, it is also necessary to integrate an awareness of women's issues and experience into all research, education and treatment planning in this area.

The need for such attention is pressing. The three challenges in *Achieving Health for All: A Framework for Health Promotion.* Reducing Inequities, Increasing the Prevention Effort, and Enhancing People's Capacity to Cope, are all directly applicable to the issue of women and smoking. Attention to the underlying structures defining women's lives in Canada will result in measurable improvements, not only in the reduction of tobacco use, but in women's health in general.

High Priorities for Action

Legislation: Continued effort must be placed on supporting and encouraging legislative efforts that reduce or eliminate the advertising, promotion and availability of tobacco. Combined with increasing restrictions on smoking in worksites and public areas, such legislation will effectively reduce women's and men's, and girls' and boys' tobacco use in Canada.

Education: The revision of existing prevention and educational materials, and the creation of new materials, increasing their sensitivity to women and women's issues, would be a major contribution to an effective strategy in reducing tobacco use in women.

Research: The design, implementation and evaluation of all studies, materials, programs, and strategies in the area of women's tobacco use, need to be assessed using guidelines that take women into account, and that specifically acknowledge sex differences.

Collaboration: Future efforts in reducing women's tobacco use in Canada must actively and deliberately involve the women's movement and all other concerned groups, and specifically target native women, young women, poor women, and unemployed women.

Chapter 1

A. Introduction

Health Inequities and Gender Inequities

In the report *Achieving Health For All: A Framework For Health Promotion*, the Honourable Jake Epp, Minister of National Health and Welfare, makes progressive statements concerning a new vision of health for Canadians. This new vision emphasizes personal choice and "quality of life" as goals to be incorporated into acquiring the state of good health. All three of the national health challenges identified in the report have direct application to the issue of women and tobacco in Canada.

The first challenge in the report is "Reducing Inequities". It is well established in many countries, including Canada, that people's health varies considerably according to their economic circumstance. People who are poor are less well than people who are rich. This is due to differential access to health resources and health care systems, differential education with respect to health issues, combined with adverse living conditions that directly affect people's health. Particular groups mentioned in *Achieving Health For All* include the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants. For all of these groups the use of tobacco is much more prevalent than for groups that experience positive health education, easy access to the health care system and comfortable living conditions.

A cursory review of the status of women in Canadian society reveals that women are much more likely to be found in lower socioeconomic groups, as sole support parents, unemployed and receiving welfare, than other groups in the population. In addition, among the aged, the poorest are female. The feminization of poverty that all of these facts represent is a global phenomenon.

The second challenge mentioned in the report*Achieving Health For All* is "Increasing The Prevention Effort". The largest challenge in prevention is to affect individual choices regarding life style and behaviour. This is an important area with respect to the issue of women and tobacco. The group most vulnerable to adopting the smoking habit in Canada are children and young women. Although more men than women smoke, the prevalence rates are converging, and young women are forming a larger proportion of smokers than ever before. As smoking is a preventable cause of illness and death, it is appropriate that prevention be the major challenge and the major focus. It is estimated that prevention could cut by 50 percent the incidences of lung cancer and heart disease in Canada (Epp: 1986:5).

The third major challenge outlined in the report is "Enhancing People's Capacity To Cope". In this context it is important to identify the radical alterations that have been made in women's lives over the past few decades. Women in Canada have entered the paid labour force in increasing numbers. However, the jobs women are doing in the labour force are not the best paying jobs, with women earning approximately 64 cents for every dollar that a man earns (Statistics Canada: 1985). The most telling social indicator, however, is the fact that while women have entered the labour force, their traditional work at home and within the family has altered very little. Numerous surveys on women's work reveal that women often do two jobs – paid and unpaid. Dependent care of the young, the disabled, and the elderly still rests mainly with female family members. Added to these stresses are difficulties encountered in finding adequate care for preschool and school age children, often as a sole provider for a family. In short, women's lives in Canada are extremely stressful. One of the responses to such stress is the seeking of stress reduction techniques, some of which may be unhealthy. Smoking is, in this sense, a functional behaviour, allowing some women to cope.

The inequalities in health and in the status of women are the two important foundations for this paper. An approach worth taking when considering the issue of women and tobacco use is to apply a gender analysis when investigating all facets of the problem. It is necessary to apply such an analysis at every level of current educational, prevention and treatment programming offered or directed to women. This means giving serious consideration to the content of programming from a woman's perspective. Secondly, assessing the sexism of the messages accompanying the health message is necessary. Lastly, a gender analysis implies that future development efforts must involve the

community of women in Canada in developing worthwhile solutions to the problem of women and tobacco.

In this attempt, it is vital to consider the role of the women's community in Canada. Formal organizations involved in the women's movement include national, provincial and local women's groups that need to be involved, not only in providing information that may guide further directions, but also in carrying out community development at a grass-roots level. Although the women's movement in Canada today is concerned with a myriad of social and economic issues pertaining to the improvement of the status of women, it is beginning to appreciate the potential for affecting government policy, social attitudes and women's behaviour with respect to tobacco and women. There are small indications at this point that the women's movement may be mobilized, to offer concrete support and concrete community development with respect to this issue in Canada.

Further, a significant and potent women's health movement exists in Canada. This has grown steadily over the last fifteen years on a regional or community basis and around specific health issues. Currently, there are organizational efforts being undertaken to create the Canadian Women's Health Network in Canada, which had its founding meeting in January, 1988 (Clement: 1987). This provided the beginnings of a formal organization that could assist in developing the community of women in this country around the issue of women and tobacco.

Up until now the issues designated by the women's health movement and by the health advocates within the women's movement have been largely reproductive issues. For obvious reasons scarce resources and energy are devoted to those health issues specific to women. Abortion access, birth control and reproductive technology, the effects of DES and Depo Provera, the medicalization of child birth and similar issues have been fundamental in the development of the women's health movement.

The issue of smoking has been seen as a behaviour that both sexes participate in (in fact, men more than women), and as one already covered by mainstream health organizations. These perceptions have prevented mobilization within the women's health movement in Canada.

Simultaneously, the medical research community, the disease control agencies and social scientists have developed and released dramatic statistics and health messages regarding smoking prevalence, prevention, and cessation for women. There is abundant development work to be done within the community of people who are attempting to affect women's smoking behaviour in Canada. In order to plan an effective national strategy, the blending of experience, research and knowledge between the various communities such as the women's health community, the medical community, the disease control agencies, and the research community is necessary.

In conclusion, the thrust of *Achieving Health For All* indicates promising directions for attacking the problem of women and tobacco. Further, it indicates an overlap of principles or assumptions with those already being made in the women's health movement in Canada. The emphasis on personal choice, holistic health planning, and the development of community resources to support decisions made by individuals in local areas are all principles that fit with those existing in current health movements.

Blending the efforts and perspectives of the various communities working on the issue, is not only possible but necessary to achieve an integrated, productive plan. In the initial stages of attempting to do this in the province of Ontario there appear to be few, if any, points of conflict. Further, complementary themes, ideas and perspectives are immediately revealed when the communities begin to share their progress and ideas towards the goal of eliminating smoking behaviour in women. Few conflicts are generated between people who have, as their ultimate goal, improving the health and well-being of women. Obviously, conflicts arise with the growers, manufacturers and advertisers of tobacco products who have vested interests markedly different than those of the groups mentioned so far. The extent of that political problem is already well documented and clearly not an issue to be taken up in this paper. However, the legislation before the House of Commons at time of writing, (Bills C-51 and C-204) is positive for all those concerned with improving the health of Canadians with respect to the issue of smoking.

Widespread cigarette smoking among women is, in historical perspective, a relatively recent phenomenon.

Prior to World War II, very few women smoked. It has been 23 years since the link between smoking and cancer has been widely publicized (U.S. Public Health Service: 1964). During this time, many programs have been launched to try to reduce the numbers of smokers in the Canadian population. Generally speaking, these have had some effect on both men and women, as the prevalence of smoking is far less than it was twenty years ago. However, those remaining, or becoming smokers today represent a challenge, as they are smokers who are to some extent resistant to the health messages that have worked on other groups. It is now important to characterize more specifically the groups that resist traditional health messages in order to create and launch more finely focussed prevention, education and treatment programs. Even though a lower percentage of women in Canada smoke compared to men, it is of concern that teenage women are the fastest growing group of smokers (National Program Directional Paper: 1987); that maternal smoking is a powerful role model for girl children (Ashley: 1983); that women and girls are particularly targeted by the tobacco industry and advertisers (Jacobson: 1986, Ernster: 1985); and that women's inequality produces smoking behaviours unique to women (Jacobson: 1981).

Most important, 13 000 women die in Canada every year due to smoking related diseases (Collishaw: 1987). Every forty minutes, a Canadian women dies a totally preventable death. Efforts to preserve the valuable human resource of women's health must be accelerated.

It must be borne in mind that women are a disproportionate part of many of the groups experiencing the inequality in health mentioned in *Achieving Health For All*. Women in Canada find themselves with more than one reason for remaining resistant to health messages. It is in this context that the application of a gender analysis is important in order to understand what changes may be necessary in the areas of prevention, education and treatment of women and smoking.

B. Issues For Future Action

1. Government, research, health and education agencies concerned with tobacco use need to consider or reconsider their activities, using a gender analysis.

   This would include:

   a) an assessment of program content, planning and priorities from a woman's perspective;

   b) an active effort to involve the community of Canadian women in assessing current activity and developing future plans concerning women and tobacco use;

   c) an assessment of research using guidelines similar to those approved by the Social Science Research Council, and published in *On The Treatment of the Sexes in Research* (Eichler and Lapointe: 1985).

2. The mobilization of the women's movement and the women's health movement on this issue needs to be encouraged and possibly facilitated by the provision of operational funding to women's health groups in Canada.

3. Consideration needs to be given to establishing a national co-ordinating committee on women and tobacco to blend the experience, research and knowledge of the women's research, educational, disease control and health communities to develop and carry out ongoing strategic planning on this issue.

4. Consideration needs to be given by all concerned to adopting a focussed planning strategy to more accurately identify subgroups of women to be targeted for smoking prevention, education and treatment.

Chapter 2

A. The Statistical Picture of Women and Tobacco

Introduction

The objectives of this chapter, which presents information on smoking among Canadian women, are four in number.

The first is to identify subgroups in the population in which prevalence or incidence of smoking are relatively high. If such subgroups can be identified, then smoking education and cessation programmes can be designed and targeted to the groups who need them the most. Variables of interest that can be used to define these subgroups include age, province of residence, ethnicity, educational level, socioeconomic status, marital status, employment status and urban-rural residency.

The second purpose is to make projections about future smoking levels among various population subgroups of women. Needed to do this would be repeat population surveys using similar methods and variable definitions. Past trends could then be assessed and projections under different sets of assumptions could be made. Again, it would be desirable to make projections for subgroups defined by the variables listed under the first objective.

The third objective is to compare smoking levels for males and females, both in terms of current levels of population subgroups and in terms of population projections.

The final objective is to assess consumption patterns in various population subgroups and any trends in these patterns. In addition to patterns of the incidence and prevalence of smoking, which serve as general indicators of populations at risk of smoking-related disease, two other indicators can be useful in targeting programmes. They are the amount of smoking, generally expressed as number of cigarettes smoked per day, and the tar and nicotine content of the cigarettes smoked. Again, it would be desirable to have these indices for various population subgroups.

Problems With The Available Information

In spite of the large number of surveys available, the type of information needed for the objectives outlined is very limited. There are a number of reasons for this. First, in many cases the collection of information on smoking and its correlates was not the primary purpose of the survey. A common consequence is that not all of the relevant information was collected. In other instances where much of the relevant smoking information was in fact obtained, analyses by population subgroups were often not possible, either because the subgroup was not covered by the survey (e.g. native women) or because the sample surveyed was too small to provide statistically reliable estimates on smoking. One must also wonder about the possible effect on these estimates of any differential response rates across population subgroups.

When analyses relevant to the current purposes based upon a particular survey have not been carried out, public use tapes may be available for a fee, or the government agency responsible may carry out the analyses upon request, again for a fee.

It must be recognized that apparent differences in smoking estimates across surveys may be attributable in part to differences in survey methods. Data have been gathered by personal interview, telephone and self-administered questionnaires. Both personal and proxy reporting has been used, and the wording of the survey questions has varied. All of these factors have been shown to have a potential effect upon survey results.

Different definitions of current smokers and, in particular, former smokers have been used in the various surveys, and none of the surveys have used biochemical measures to validate smoking status reports. Finally, many of the surveys have been carried out only once (e.g. Health Promotion Survey, General Social Survey, Canada Fitness Survey), thereby making trend analyses virtually impossible.

Some *general* statements can be made about incidence, prevalence, subgroups needing targeting, comparisons and projections with a fair degree of confidence. However, the information needed to meet

the objectives in a more precise way is not forthcoming, because of the problems and limitations cited above.

Smoking Patterns for Women

The figures presented in this section come from the Canadian Labour Force Survey (CLFS) and the Smoking Behaviour of Canadians Survey, which is a supplement to the CLFS. These surveys have been carried out since 1964, thereby providing data on trends, with the most recent one being done in December, 1986. The recent survey was based on a multistage probability sample of over 30 000 Canadians (excluding the Yukon and Northwest Territories). Many of the variables of interest outlined above, including consumption patterns, are available for analysis. While there may be some under-reporting of smoking in these surveys because of proxy reports, inspection of the estimates from the General Social Survey and the Health Promotion Survey support the contentions that the patterns across population subgroups are in general the same, and that the estimates from the other surveys fall within the margin of sampling error of those from the CLFS. It seems likely, therefore, that the CLFS estimates represent minimum values. The only sub-group of *major* concern would be the younger age groups (15 to 19) where proxy reporting is sizeable and there is other indirect evidence to indicate misrepresentation may be a problem (Pederson and Lefcoe, 1985).

The tables and figures are from a preliminary report by W.J. Millar, *The Smoking Behaviour of Canadians* – 1986 reprinted with his permission. All tables presented are for percentage estimates for the population and for both males and females.

Figure 1 presents the overall smoking levels for males and females from 1966 to 1986. It is of interest to note that there has been a decline in consumption for both sexes, with a more marked decline being evident for males. Current estimates indicate that across Canada 30.8 percent of males smoke, while 25.8 percent of females do so.

Age (Figure 2, Appendix A – Table A). The highest levels of regular smoking (approximately 32 percent) for women occur in the 20 to 44 year age range. The level is slightly less than for men in the same age range (approximately 35 percent). The percentage of former smokers increases with age for men in a more or less linear fashion from less than 10 percent to 50 percent, but for women, the percentage is relatively constant at less than 20 percent. This likely reflects the fact that fewer women than men in the older age groups are

Figure 1
Prevalence Of Regular Cigarette Smoking In The Population 15 Years Of Age And Over By Sex, Canada, 1966-1986

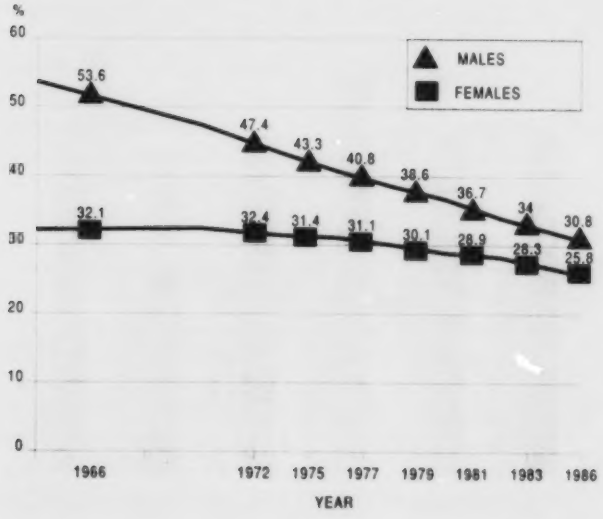


Figure 2-a
Percentage Of Regular Cigarette Smokers In The Female Population 15 Years Of Age And Over By Age, Canada, 1966-1986

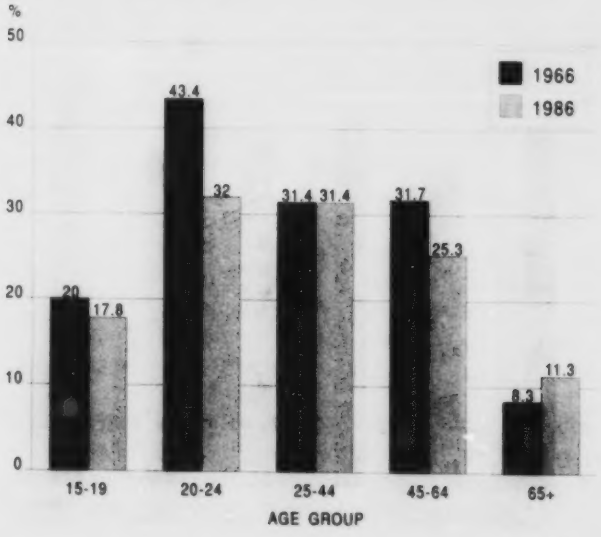
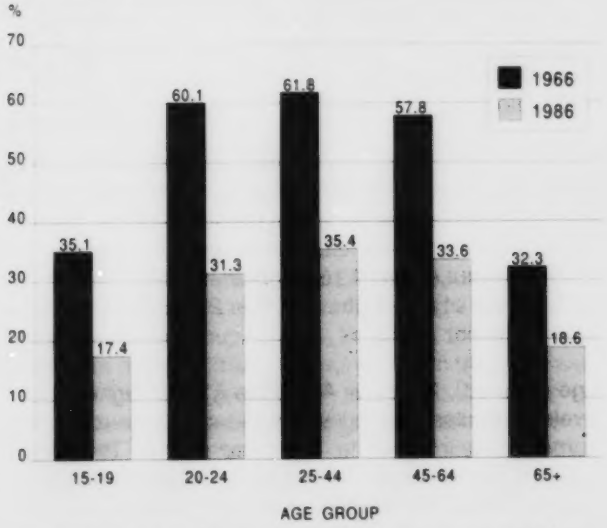


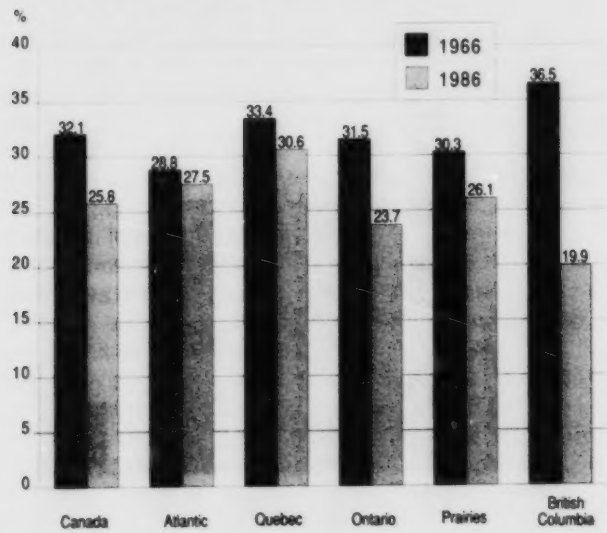
Figure 2-b
Percentage Of Regular Cigarette Smokers In The Male Population 15 Years Of Age And Over By Age, Canada, 1966-1986



candidates for quitting by not having taken up smoking in the first place.

Province (Figure 3, Appendix A – Table B). The highest levels of smoking for women occur in Quebec (30.6 percent), followed by Nova Scotia and New Brunswick. The lowest levels occur in Prince Edward Island and British Columbia. Where smoking levels are high, the prevalence figures are highest for the 20 to 44 year olds, indicating that these women may comprise an important target group for future programming.

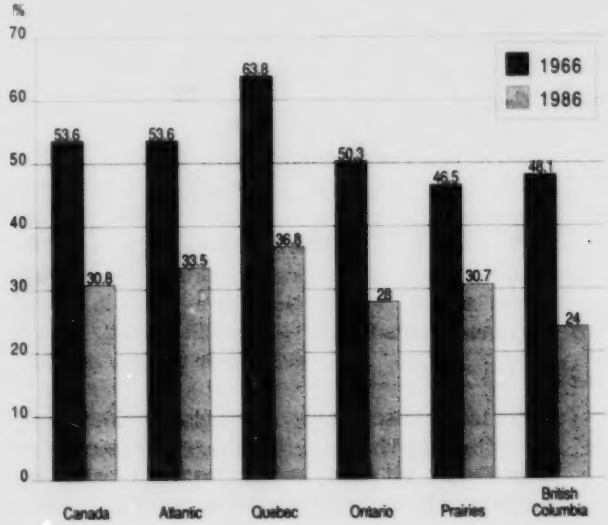
Figure 3-a
Percentage of Regular Cigarette Smokers In The Female Population 15 Years Of Age And Over By Region, Canada, 1966-1986



Data from a supplement to the 1985 Health Promotion Survey on smoking in the Northwest Territories (Table K) reveal that approximately 50 percent of both males and females are current smokers, as compared to 34 percent for the Canadian population as a whole. The highest levels of smoking (61.0 percent for females and 68.9 percent for males) are found in the 20 to 24 year-old age groups. Smoking levels for females are higher than for males among two groups, with reported levels of 78.6 percent for females and 73.7 percent for males for Inuit people and 66.2 percent for females and 57.8 percent for males among the Dene. For non-natives, prevalence of smoking for males is higher at 42.4 percent than is prevalence for females at 37.2 percent. There is certainly cause for concern about future smoking levels in this part of the country and the need exists to develop programmes for both women and men, particularly for native groups and younger people.

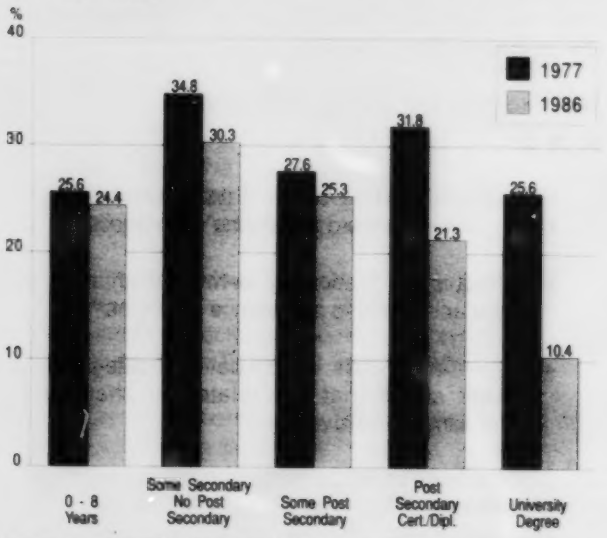
Educational Level (Figure 4, Appendix A – Table C). For women, there is an inverse relationship between smoking prevalence and level of education that is even

Figure 3-b
Percentage Of Regular Cigarette Smokers In The Male Population 15 Years Of Age And Over By Region, Canada, 1966-1986



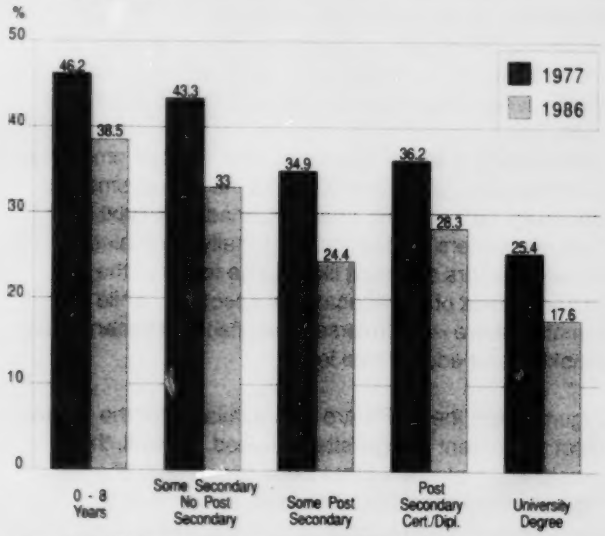
more striking than the trend for males. The only exception to the trend is found in the 0 – 8 years group for women, which at 24.4 percent is lower than the next educational category. Women whose educational achievement is not beyond secondary school are three times more likely to be regular smokers than those who have a university degree (10.4 percent). Because this association is observed in every province, national programmes with this specific group in mind might be in order. When age is taken into account, the highest levels (at close to 40 percent) occur for the 20 to 44 year old women who have not gone beyond secondary education, again delineating a possible target group.

Figure 4-a
Percentage Of Regular Cigarette Smokers, Women Aged 15 Years Of Age And Over By Education, Canada, 1977-1986



Occupation (Appendix A – Table D). The pattern of smoking prevalence by occupational category is somewhat different for men and women. For men, the lowest prevalences can be found in managerial (23.6 percent) and professional (20.6 percent) categories, while for women the managerial category is not one of the lower (28.6 percent). In fact, in this category (and marginally in service and sales), prevalence for women is higher than for men. The highest level of smoking for women occurs in the mining (39.4 percent) category, followed by other crafts, service, transportation, construction and clerical workers. The levels for occupational category probably reflect to some degree the relationship between smoking and educational achievement, the exception being the managerial level. Certainly, worksite programs would be in order. In determining when such programs should take place, it is important to consider the percent of employed women in a particular category, in conjunction with smoking prevalence. For example, 29.5 percent of female clerical workers (who comprise 30 percent of employed females) smoke. Programs targeted to these women may reach many more smokers than ones for women smokers in mining (39.4 percent) who comprise 2.3 percent of employed women.

Figure 4-b
Percentage Of Regular Cigarette Smokers, Men Aged 15 Years Of Age and Over By Education, Canada, 1977-1986



Consideration should also be given to women and men not in the paid labour force who would therefore not have access to worksite programs. Overall, smoking prevalence is higher among the unemployed (41.4 percent) than among those employed (30.0 percent) and those not in the labour force (23.2 percent) Table L. This pattern holds for males in all age groups except those who are 45 to 54 years old and for females, except those who are 55 to 64 years old. Certainly, these individuals comprise a group who are in need of programs outside of the worksite.

Marital Status and Smoking Environment (Appendix A – Table E) Smoking levels tend to be higher among separated, widowed or divorced ("other" category) individuals, than among married or single people for

both males aged 25 to 64 years and females 20 to 64 years. The highest levels occur at ages 25 to 44 for males (53.4 percent) and 20 to 24 for females (65.3 percent). Also smokers are more likely to exist in a smoking environment; that is, they are likely to have spouses and friends who smoke (Health Promotion Survey, 1985).

Consumption (Appendix A – Tables F, G, H). In terms of number of cigarettes smoked per day, males are more likely to be heavier smokers than are females. However, the heaviest smoking levels for women are found in the 25 to 44 year age range, whereas for men, the heaviest smoking levels occur in the 45 to 64 year-olds. There appear to be more heavy smoking males and females in British Columbia than in other provinces, a curious fact, given that B.C. has the fewest smokers generally. Quebec and Atlantic Canada are next for high consumers for both sexes. Finally, for males, heavy smokers are most likely to be found at the extreme ends of the educational spectrum, while for females, there is an inverse relationship between heavy smoking and educational level.

Figures from the CLFS are also available for the tar and nicotine content of cigarettes smoked. Overall, they reveal that males are more likely to smoke higher tar cigarettes than females. This pattern was evident across regions and educational levels. There is a tendency for older women in the Atlantic Provinces and Quebec and those with higher educational levels to smoke lower tar and nicotine cigarettes. Caution should be exercised in interpreting these findings in light of evidence that suggests that compensation in smoking may occur through increased numbers of cigarettes smoked or changes in number, duration and depth of puffs per cigarette.

Trends (Tables I, J). For males in all age groups, there has been a decline in the prevalence of regular smokers over the past 20 years. For females, however, this consistent pattern has not emerged. While there has been a decline for the 20 to 24 and the 45 to 64 year old groups, recent decreases for the 15 to 19 and 25 to 44 year olds followed earlier increases, and as a result the figures for 1966 and 1986 are similar.

In addition, figures from the CLFS are available that indicate that the greatest reduction in smoking occurred for women in British Columbia, and that women who have achieved higher educational levels show greater declines in smoking prevalence than those with lower levels of educational achievement.

Also, when trends in consumption are examined, heavy smokers of both sexes appear to constitute a growing proportion of all smokers. Women ages 15 to 24 are the major exception to this trend. Reasons for this are not known but may include greater cessation among lighter smokers as well as increasing levels of smoking and lower cessation rates among those who have shifted to low tar and nicotine cigarettes.

B. Issues for Future Action

5. Further analysis of available data sets needs to be done, directed toward answering such questions as:

   - What is the relationship between marital status, age and smoking prevalence over time?
   - Are there trends in occupational categories or work status that are related to changes in smoking habits over time?

   Comparisons could be made in order to assess if patterns are different for males and females.

6. Collection of clearcut information needs to be done for the younger age groups, in order to assess whether smoking levels are really lower or an artifact of the data collection procedures. (It is necessary to avoid proxy reporting and to ensure confidentiality.)

7. Attempts are needed to determine why there are subgroups among the population with high smoking levels. Questions about reasons for smoking could be directed toward groups already identified. Also, answers to questions about reasons for quitting might be useful for program development among those subgroups with large numbers of ex-smokers.

Sources of Information

The sources of data used in this section include the following:

1. *Canada Fitness Survey. Fitness and Lifestyle in Canada.* Government of Canada, Fitness Canada, 1981.

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3. Canadian Gallup Polls 1982-1986.

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5. Health and Welfare Canada. *Smoking Habits of Canadians: 1965 to 1979.* Ottawa: Health Promotion Directorate, Health and Welfare Canada, 1980, Technical Report, Series No. 9.

6. Health Promotion Survey, Supplementary Data on Smoking in the Northwest Territories, 1987.

7. Jossa, D. *Smoking Behaviour of Canadians, 1983.* Ottawa: Health and Welfare Canada, 1985, Cat. #39-66/1985E.

8. Lamarche, P. Health Promotion Survey. *The Use of Tobacco in Canada, 1985.* Draft report 11/86.

9. Millar, W.J. *The Smoking Behaviour of Canadians, 1981.* Ottawa, Health Services and Promotion Branch, Health and Welfare Canada, 1983.

10. Millar, W.J. *The Smoking Behaviour of Canadians, 1986.* Ottawa: Health Services and Promotion Branch, Health and Welfare Canada, 1987 (Unpublished manuscript – preliminary draft).

11. Pederson, L.L. and Lefcoe, N.M. Cross-sectional Analysis of Variables Related to Cigarette Smoking in Late Adolescence. *Journal of Drug Education, 1985;* 15(3), 225-240.

12. Thomson, M.E. *Statistics of Smoking in Canada,* Canadian Council on Smoking and Health, November 1984.

Note: (1) through (4) are based on Labour Force Surveys.

Chapter 3

A. Initiation Of Women's Smoking Behaviour

Why do women start smoking, or more accurately, why do girls start smoking in the first place? According to surveys from Health and Welfare Canada the onset of smoking usually takes place between the ages of 12 and 14 for both boys and girls. Most of the reasons are social: advertising influences, role models, especially maternal, and the desire for peer acceptance. Psychological influences include the need to identify with adult behaviour through smoking; acceptance of smoking as a "rite of passage" (Robb: 1986); the attraction of smoking as a weight control mechanism or an appetite suppressant; and the understanding of smoking as a behaviour that represents risk taking, emancipation, freedom and sexual attractiveness (Gritz: 1984).

Low-Nicotine Cigarettes

Although there can be no physiological factors influencing the initiation of smoking, during the process of learning to smoke, light or mild cigarettes, produced by manufacturers specifically for teenage girls and women, allow the body to adapt to smoking behaviour. Silverstein et al (1980) suggest that the availability of low nicotine cigarettes facilitates the initiation of smoking in teenage girls. Despite manufacturers' and advertisers' claims that the youthful market is not their target, it is well accepted that attracting this market to the smoking habit is crucial to maintaining the health of the industries.

Advertising Influences

An Australian study of children found that "approval of cigarette advertising" was a strong predictor of whether a child would begin to smoke (O'Connell: 1981). Another study among adolescents found that heavily advertised brands of cigarettes were much more often selected for purchase by adolescents than by adult smokers (Chapman and Fitzgerald: 1982). Coupled with the fact that children in this age group are less likely to have accurate health information about the effects of cigarette smoking, the role of advertising takes on even more importance in influencing the initiation to smoking behaviour.

Family Influences

A useful developmental model explaining teenage female smoking has been offered by Ellen Gritz (1986). The process of learning to smoke begins with the *preparation oranticipation* stage where the influences of siblings and parents make the difference in the development of attitudes towards smoking. The influence of role models has the most effect in this stage. The behavioural aspects of smoking; acculturation to the smell and sight of cigarettes and to learning the posturing involved in the physical act of smoking, are displayed for the teenage girl at this stage.

There is dramatic evidence regarding the influence of parental smoking and parental permission to smoke. In a Norwegian study, for instance, "of students age 15 whose parents both smoke, 62.5 percent smoked daily when permitted to smoke by their parents, against 16.7 percent when not permitted" (Bjartveit, Lochsen and Aaro: 1981:407). German evidence indicates the importance of the first five years of life, where mother's smoking patterns create the awareness of cigarettes for both male and female children (Schwarz: 1983).

Peer Group Pressure

In the stage of *initiation* or experimentation, where the young girl is attempting to smoke her first cigarette, the peer group plays the most important role. First, cigarettes are usually smoked in the company of friends and having friends who smoke is the best predictor of future smoking. These initial peer group experiences with cigarettes occur most frequency with persons of the same sex. Smokers and non-smokers alike tend to stick together in the adolescent period.

Once the young girl has learned how to smoke, there is a period of *experimental* smoking in which her self image as a smoker becomes reinforced. During the stage of experimentation, the teenage smoker must adjust to the pharmaceutical effects of nicotine and in so doing, searches for an appropriate brand. Advertising has a huge effect at this point on brand selection. Once the experimentation phase is over and the teenage girl has accustomed herself to the effects of nicotine, dependence begins to develop, a habit is established and other uses of cigarette smoking such

as weight control or appetite suppressant come into play.

Self Image and Body Image

The initiation of smoking behaviour needs to be interpreted in the context of wider studies of teenage girls' behaviours and characteristics. One study of teenage girls attending schools run by the London Board of Education indicated two out of three had dieted by the age of 13, and 30 percent of these girls had used drastic measures, such as drugs, laxatives, vomiting, etc., in their dieting process (Brooks and Chansonneuve: 1986). A sharp decline in sports participation and physical activities at the ages of 13 and 14 was typical of these girls. They prided themselves on their competence in interpersonal and social skills, such as being a good friend, being able to talk to friends, being fun to be with and being honest. Taken together, three general characteristics of teenage girls indicate a context in which smoking behaviour can easily take root: the importance of the peer group, the interest in realizing the ideal of extreme slimness, and the dropping of interest in physical activity and sports.

This age marks the beginning in a girl's development of placing the control for her life on external elements such as teachers, family, luck or faith. Not only is this trait different from boys who are more likely to place credit for their successes on internal factors or characteristics, but these differences between internal and external loci of control persist between men and women as adults (Tavris and Offir: 1977: 189). It is in this context, then, that young girls must be studied as they become initiated to smoking behaviour.

Interactive Effects

Abelin (1983) offers a convenient epidemiological model to explain the onset of smoking in children. He clarifies the interaction between the environment, the host (the child), and the agent, (cigarette). The availability and attractiveness of the tobacco or cigarette is an important factor regarding onset. With respect to the environment, role models at home, school, among friends, and in advertising, feature prominently. With respect to the child herself, self-image, her involvement with others on non-smokers' rights activities, knowledge of health effects, and skills in decoding advertising are all important factors affecting the onset of smoking.

B. Prevention Issues

Much prevention work in smoking education is aimed at children and teenagers. This work is based on the assumption that if the onset of smoking in children can be prevented, then the prevalence of smoking among adults can be reduced. Although this premise appears logical, it is only an assumption, and as Donald Reid (1983: 136) points out, "It might be equally true that success in reducing children's smoking will only lead to a postponement in the onset of regular smoking." This is clearly an area in need of future research.

The School Curriculum

Since 1979 a number of countries have improved their statistics regarding children's smoking behaviour (Reid: 1983). Most of these efforts emphasized school curriculum approaches: improving and widening the thrust of smoking education. This education has been directed at children from age six to fourteen, and includes information on health effects of smoking, skills development in resisting advertising, assertiveness training to deal with peer pressure, and games and exercises that challenge the children. Children are often taught to identify the influences in advertising and social groups in order to resist them. Although many of these efforts have been artificial in some ways, or methodologically weak, statistically significant results have been acquired. Generally, school curriculum projects have been vastly improved in the last decade and have resulted in some valuable teaching for children (Reid: 1983).

The results of these studies however, must be assessed in the context of the larger society. In the last ten years smoking prevalence among adults has fallen in most industrialized countries as health information and the community opinion regarding the acceptability of smoking has changed markedly. It is less clear what has an effect on reducing the onset of children's smoking.

Availability

Given concerns about availability, stronger and more consistently enforced legislation regarding sales of cigarettes to minors could be an important influence in preventing the onset of smoking among children.

One million dollars worth of cigarettes were sold to Manitoba youth in 1985, and the Non-Smokers Rights

Association estimates that children across Canada buy $260 million of cigarettes per year McInnes: 1987). This demonstrates the ease of accessibility to tobacco that children experience through retail outlets and vending machines.

The Environment

Environmental factors such as the presence of smoking zones or availability of ashtrays can also strongly influence onset (Abelin: 1983:246). Education aimed at preventing children's smoking, but directed at parents and teachers, giving them salient facts about ages of onset and environmental influences on children may also have a marked effect on children's behaviour in this area. Since children and adolescents are particularly sensitive to advertisements, (Chapman: 1985) a total ban on advertising of tobacco products may benefit this age group in particular.

After the introduction of a total ban on advertising in Norway in 1975, consumption and prevalence figures quickly began to decline among teenagers. By 1980, rates, particularly for girls, had shown improvement, with the girls' rate once again lower than the boys' (Bjartveit, Lochsen and Aaro: 1981:410).

Reversing Peer Pressure

An interesting Australian study testing the "social consequences curriculum" in high schools revealed that peer pressure and 'intention to smoke in the future' were the significant predictors of uptake of smoking in young girls (Fisher, Armstrong and de Klerk, 1983). Although a teacher-led curriculum had a positive effect on both sexes during this program, a peer-led program of identical design had an equal effect on girls but appeared to be ineffective with boys. This result indicates a potential benefit in reversing peer pressure for young girls and may offer a design for programs specific to preventing the onset of smoking in girls.

In conclusion, prevention efforts must continue to be directed at young children and teenagers, even during the experimental smoker phase. These must be primarily educational, aimed at improving the health knowledge and social skills of children in resisting peer pressure, advertising influence and environmental factors. These prevention activities, however, must be co-ordinated in a holistic community approach. Equal attention must be paid to improving the strength of legislation regarding the sale of tobacco and advertising, smoke-free area legislation and other wider environmental measures. These undoubtedly have a particular effect on the teenager and young child, as well as on the general population. It will remain counter-productive to have stronger and more successful smoking prevention education programs within the school, only to have the child exposed to slick, influential advertising outside the school grounds and uninformed, permissive parents at home.

The serious question remains, however, as to whether the prevention of onset of smoking in children in fact reduces the onset of smoking in younger women (or in younger adults in general). This question needs particular investigation.

C. Issues For Future Action

8. Continued effort needs to be placed on:

   a) passing legislation banning the promotion and advertising of all tobacco products;

   b) revising legislation regarding sale of tobacco to minors to include stiffer penalties;

   c) developing public awareness programmes among retailers to inform them of legislation regarding sales to minors, and

   d) passing legislation banning vending machine tobacco sales, to limit accessibility to children.

9. Consideration needs to be given to the development of:

   a) an awareness program directed to parents, identifying environmental, social and psychological influences affecting smoking initiation in young girls, and measures parents can take to ameliorate them;

   b) school health curricula for girls, linking and contextualizing the issues of body and self-image, eating disorders, substance abuse, physical inactivity, emotional dependency, contraceptive use and smoking; and

c) a mobile museum of smoking-related artifacts and advertisements, to educate the public, but especially children, and to place tobacco use in a historical context.

10. The need for the encouragement and development of research initiatives in:

    a) investigating the relationship between eating disorders and smoking in girls, and

    b) investigating whether prevention of smoking onset in girls and teenagers is permanent, or whether delayed onset in adults occurs.

11. Continued emphasis needs to be placed on getting the support of provincial ministries of education to direct boards of education to eliminate smoking in all schools.

Chapter 4

A. Maintenance Of Women's Smoking Behaviour

Once they have started, why do girls, and then women, continue to smoke? Of particular interest are studies aimed at distinguishing motivations for smoking among the late adolescent group. Pederson and Lefcoe (1985) investigated a group of male and female adolescents, (mean age of 17), through tracking high school records. This group had been studied ten years earlier as grade 4 to 6 students. In general, the smokers in this particular group were "older, female, had less knowledge about smoking and more positive attitudes towards it, had more friends and parents who smoked, were less physically attractive and in poorer physical condition, did more poorly in school and had parents who were less well-educated and were of lower SES" (Pederson and Lefcoe: 1985:232). An important result of this study shows that for late adolescent females, the 'attitude toward smoking' was the best indicator of smoking, whereas for young men, peer smoking was the best indicator. At a younger age, peer smoking or peer attitudes toward smoking had been better indicators of smoking behaviour in women. This suggests that reasons for smoking, for young women, fairly quickly become "internalized".

The *maintenance* of smoking behaviour is an important phase of smoking behaviour to be studied in its own right. It is useful to group factors influencing maintenance into social, psychological, and physiological categories.

Psychological influences include a fear of weight gain, a desire to control weight through cigarette smoking, the use of cigarettes as stress release, the function of smoking as a route to immediate pleasure gratification, or a social-psychological need to use cigarette smoking to support an image.

Social factors continue to include friends, partners and family members who smoke, the availability of smoking companions and smoking zones in the work-place, the influence of tobacco advertising directed at young women and women in general, and the manufacture and promotion of specific tobacco products directed towards the women's market.

In addition, physiological factors begin to play a part in maintaining the behaviour. Once a girl becomes a regular smoker, her body accustoms itself to regular nicotine dosages and thereby develops a dependence or addiction. The co-ocurrent use of alcohol, and coffee or other caffeine products, with cigarettes, provides a synergistic complex of influences on the body that become associated with the behaviour of smoking (Carmody et al: 1985:332).

The key elements of why women persist in smoking in the face of negative social attitudes and increased awareness and education on specific health risks for women remain elusive. However, the psychological, physiological, pharmacological and sociological influences clearly weave together to promote the maintenance of smoking behaviour in a context of external factors such as the advertising, promotion and manufacturing of specific tobacco products for women.

It is important to realize though, that as young girls become young women, the motivation for smoking appears to shift. According to Pederson (1986:37), "continuation of smoking is not so much under the control of social factors as it is under individual personal ones". Consequently, although social and health messages continue to be important in the educational campaign directed at the maintenance of smoking behaviour, an additional area of personal messages needs to be developed. These messages need to confront directly the matter of dependence upon cigarettes in the broadest of senses.

Psychological Influences

In the psychological domain, authors have suggested that smoking among women is potentially a response to anger (e.g. Beckwith: 1986). In related work, she found that for adult women smokers "cigarettes were more important that either food or alcohol" (1986: 1087). This may be evidence that smoking becomes a way to avoid eating, an appetite suppressant, or an aid in dieting. Given the cultural pressure to maintain an ideal body weight and to aspire to an unrealistically thin body weight, women are consequently very concerned about

the weight gain that may result if the smoking habit ceases. Although some interesting research exists in the area, (e.g. Grunberg: 1985) more research needs to be done to establish exactly when and how body weight changes when smoking stops. Then, mechanisms can be suggested to women (and men) to prevent this particular side effect of smoking cessation.

The much more important education that needs to take place, however, is aimed at redefining ideal body weight for women. Work in this area would contribute to more body self-acceptance and consequently a better self-image for women, despite the cultural stereo-types. Deflating the 'thinness' ideal would contribute significantly to removing the fear of weight gain as a barrier to cessation. Education messages linking the oppressive aspects of both dieting and smoking may be useful in this regard.

The idea that women smoke to be like men or to gain the advantages of being male, has been roundly critized by many feminist thinkers (e.g. Jacobson: 1986). This assumption has often been based on superficial and intuitive analyses of trends. In fact, evidence from Norway (Eide: 1983) shows that the most emancipated women in Norway are most likely to be non-smokers. What needs to be studied considerably more are the social expectations placed on women that produce the need to continue to smoke. Such study would include an analysis of the inequalities that women experience in our society, such as the significantly increased workload after entering the paid labour force, the high level of responsibility in maintaining the emotional security of the family unit, and the unacceptability of expressing anger in an externally focussed way. In short, women must be seen as a *group* in our society, distinct from men with respect to their social status. Unless this principle is understood, an understanding of why women continue to smoke and resist quitting smoking will remain incomplete.

An important thrust in the research needed on these questions is to collect qualitative data directly from women smokers analyzing their own behaviour. In such data, clues to the meaning of smoking for women will be acquired. These clues will assist immeasurably in producing effective educational materials for this particular target group.

Coping

Smoking as a coping strategy was studied in depth by Revell et al (1985) in the United Kingdom. These authors conclude that the "social aspects" of smoking become less important as the habits develop. Specifically, as dependence increases, the importance of brand image and the design of the advertisements has less impact. The same authors find that as the years of smoking increase, the smoking behaviour is spread over the morning, afternoon and evening of both weekdays and weekends as opposed to being specifically situated in the evening hours (Revell et al: 1985:223).

The major finding of these authors, however, is an interesting sex difference. Most male smokers cope with stresses in living by using 'self help' strategies, including sorting out their own problems, or solving their problems using drugs (including nicotine). Although all smokers studied used alcohol, tea and coffee more than non-smokers, the females in this study were more likely to cope with problems by talking to other people, including parents, friends and doctors, than by administering other 'self help' mechanisms.

Extrapolating from this finding leads us to conclude that males may develop a 'self help' strategy on a number of levels, negative or positive, more often than females. This may explain the success of males in smoking cessation programs based on 'self help' models. It also indicates that females may need to consult with, and exchange experiences with others, and to get others' views of them, in order to change their behaviour or even to merely cope with problems in living. This needs to be considered in redesigning cessation programs for women.

Some writers, including Revell et al (1985) and Hadaway and Beyerstein (1986), have indicated that smoking is a functional behaviour. Coping with life with the assistance of smoking needs to be viewed this way in analyzing the maintenance phase of smoking behaviour in women. This is a useful conceptualization, not only for education and cessation program planning, but also in understanding why women smoke. For example, if smoking is a coping strategy that is functional, it may be serving as a release valve for the effects of inequality that women experience, both at home, at work and in society at large. Accepting the functional value of smoking as a coping strategy, allows us to consider how changing other elements of women's lives

may be part of an effective overall tobacco control program.

Unhappiness, Negative Life Events, and Smoking

A survey of 978 adult women smokers in New Zealand (Chetwynd: 1986) reveals that smokers were more likely to be from blue collar backgrounds, to report "family problems and depressive symptoms", and to make excessive use of other dependency type substances. Equally significant, however, is the report from the same survey that on every single indicator of problems and happiness levels the smokers were more unhappy than the non-smokers. This study also reaffirms the important influence of maternal smoking, and the lesser importance of paternal smoking as an indicator of a girl's future smoking (1986:15). Class levels were attributed based on prior occupation as most of the women in this study were currently working in the home. The importance of this survey is that it describes a group of women smokers considerably different from the image of the woman smoker promoted in advertising. The life promoted in tobacco advertising represents an experience significantly different from their own on social, psychological and economic dimensions.

Results from the (American) National Survey of Personal Health Practices and Consequences, conducted by the National Centre for Health Statistics in 1979, reveal some interesting characteristics, not only of smokers, but also of health practices of women in general. Gottlieb and Green (1984), used data from this survey to assess social networks and health life-styles of women. Inequalities in health are perceived to stem from the experience of negative life events and the individual's ability to cope (negatively or positively) with them. Put differently, stress, associated with being poor, young, unmarried, and female etc., is produced by life events that are unpleasant, undesirable, or outside of the individual's control. The female poor and uneducated are particularly vulnerable to poor health, according to this model. In this study, poorer women suffered more stressful events in their lives and exhibited fewer positive health behaviours. Female non-smokers were more likely to be married, to be church attenders and less likely to be alcohol consumers than were female smokers. Even though a wider social network (as indicated by marriage) is a positive influence toward non-smoking, the more specific finding in Chetwynd (1984:15) indicates that having a smoking partner is a very powerful indicator of a women's smoking status. These findings are not necessarily contradictory, but the Chetwynd article provides a more focussed look at the family dynamics as they relate to the smoking behaviour of women.

Sociological Influences

Understanding the socialization process and resultant social learning theories proposed to explain initiation, maintenance, and cessation of smoking behaviour is useful, as socialization does not stop at adolescence, but rather continues throughout life. Consequently, approaching the experience of the young or older adult women smoker from this perspective is still a fruitful line of thought and research. Although it is correctly assumed that the peer group and other social factors exert a very strong influence in adolescence, it can also be assumed that social influence extends to adult women as well. Gottlieb (1982:596), states "smoking behaviour may shift with such life course events as marriage, the birth of a child, divorce or entry into the labour market."

In a study done by Gottlieb of Boston college-aged women, the importance of role modeling for young women from same sex parents and peers was underlined with respect to smoking initiation and maintenance. Not only does the same sex peer group influence the environment by stimulating smoking or making smoking materials available, but the act of smoking can increase group intimacy and solidarity. This power of the peer group has obvious implications for the resisting of cessation in young women.

Class, Occupation and Smoking

The most striking aspect of smoking behaviour in women is in the relationship to social class and occupational factors. People of the lower class, and of blue collar or pink collar occupational categories, are more likely to smoke than people of the upper and middle classes. As women are disproportionately clustered in lower and middle class occupations, this is of particular importance to the issue of women's smoking behaviour. A study of Sorenson and Pechacek (1986), indicates that this relationship is so pronounced that prevalence rates of smoking by sex differ largely by occupational involvement (1986: 364). Based on their study of over 3 000 workers in various Minneapolis work sites, smoking rates and interest in cessation differ markedly

between blue collar occupations and professional and managerial occupations. In this study, the overall factor of importance in determining cessation interest and prevalence was occupation, not gender.

Working women experience stresses different from men due to the pressures of both paid and unpaid work and other role conflicts. Such factors produce work-related stress across socioeconomic groups, not just in the lower status groups. However, the clustering of Canadian women in the lower status occupational groups, the introduction of Canadian women into non-traditional blue collar occupations, coupled with the traditional ghettoization of women across the occupational structure in nursing, teaching and secretarial work are all factors which indicate that women are disproportionately exposed to occupational stresses that may induce or support smoking behaviour. Further, as stated in Chapter 2, the unemployed and those receiving various sorts of social security benefits exhibit higher prevalence rates of smoking behaviour (Hay: 1984). In a New Zealand survey of census data reported by Hay (1984), the unemployed had the highest proportion of smokers in the population (56 percent men, 52 percent women). Explanations for these trends include stress in these occupation or status roles, stemming from insecurity, unpredictability, or lack of control over one's work life.

In addition, it must be postulated that health education efforts geared to the middle and upper classes may have eluded some of these groups, either in the content of their messages or the level of literacy and education demanded to understand the messages. The disproportionate number of women in these occupational categories or as receivers of social security benefits must be noted.

As a health profession dominated by women, nursing has come under special scrutiny by smoking and health researchers. Although nurses have been unfairly maligned as having higher smoking prevalence rates than women in general, when in fact they smoke at approximately the same rate, they do in fact represent a unique case. In comparison to rates of cessation among other medical workers, nurses do not measure up very well (Stellman and Stellman: 1981:30). For an occupational group expected to be highly sensitized to the health consequences of smoking, nurses exhibit a fairly poor record. It must be noted that many of the studies reporting nurses' prevalence rates include practical nurses or R.N.A.'s in their calculations. Obviously this distorts the rates as it is to be expected that the lower-status nurses would have higher prevalence rates than the higher-status nurses.

An important article by Hawkins et al (1982), surveying nurses in the U.K., dispels some of the myths about nurses' smoking rates. They found that female nurses smoked slightly less, whereas male nurses smoked significantly more than their counterparts in the general population (Hawkins: 1982:21). A stress model was used to explain the smoking behaviour of this 50 000 nurse sample. Hospital nurses found night duty, working in psychiatry or emergency, nursing school examinations and heavy work loads to be aspects of stress in their jobs. A significant finding in this study is that 38.9 percent of the nurses who smoke acquired the habit during nursing training and a further 7.5 percent acquired the habit after qualification as a nurse (Hawkins et al: 1982:20). This finding has grave implications for understanding maintenance as well as initiation behaviour. It implies that more work needs to be done to understand initiation in adult women in particular occupational and life circumstances.

The fact that community nurses experienced a far lower rate of smoking than hospital nurses supported the notion that having control over the work environment reduced the level of smoking. The principle demonstrated is that when a person feels as internal locus of control (i.e. they feel they have more control over the outcome of their actions and over their environment), they are, in general, less likely to smoke. This finding can be extrapolated to explain the smoking rates of those on unemployment of social security benefits, those who are victims of violence (such as wife battering or sexual abuse), and those in certain blue collar occupations.

Natives and Smoking

The stress of being doubly disadvantaged through both racial and sexual discrimination, is apparent when comparing smoking prevalence rates of Indian women and white women.

McIntyre and Shah (1986), after surveying 678 Indians in Northwestern Ontario, reported that over half the population smoked. By gender, 48 percent of the female Indians in the study sample were smokers

(1986:348). In the 15 and 24 female group, almost 70 percent were smokers. Although men in this study sample smoked more than women, the vast majority of smokers in this ample were under 35 years old. Among Inuit girls and boys of the Northwest Territories, Millar and Van Rensburg (1983) report rates of 61 percent and 55 percent respectively. In addition, the use of smokeless tobacco is a considerable problem for Inuit boys in the younger age groups. Among Inuit adults, Rode and Shepherd: 1984, report rates of smoking for Inuit men and women as 81 and 93 percent respectively. Similarly, the 1985 Health Promotion Survey data on the Northwest Territories (see Table K) reveal that female smoking rates among the Inuit (78.6 percent) and Dene (66.2 percent) people are higher than the male rates. These figures indicate the smoking problem among native peoples in Canada, particularly women, is severe and likely to become worse unless immediate and specific plans are made for targeting this population.

It must be noted that particular resistance is offered by native people to pressures to control the use of tobacco. Tobacco use is seen as a cultural possession of native people whereas alcohol is viewed as the cultural possession of white people. Therefore, there is an expressed intent to maintain and retain ownership over the use of tobacco within the native community in Canada. Much ritual and religious meaning is ascribed to the traditional use of tobacco, and these attitudes persist in explaining why tobacco use is not generally proscribed among native people.

Further, many ceremonial and medicinal uses of tobacco among North American Indians have long been made without developing many habituated smokers (Fairbanks: 1985). However, the relatively recent practice of daily cigarette smoking, and its attendant morbidity has led Indian health workers in Arizona to institute non-smoking education and a tobacco free policy at the Keams Hospital on the Hopi Indian Reservation. As increasing awareness of the dangers of alcohol in destroying the fabric of Indian life is made by Indian leaders, it is possible that useful linkages may be drawn in promoting non-smoking among natives as well. This idea needs further development in the context of a holistic, native-controlled smoking education program.

B. Education Directed To The Current Smoker

Education about the health consequences of smoking and related matters is the main response to those adults who are maintaining the smoking habit. The transmission of information about health consequences of smoking for women remains an important task. Increasingly important, however, is the transmission of educational messages concerning the mechanics of advertising tobacco products, the creation and manufacture of specific tobacco products for women and girls, the overall politics of tobacco marketing, the legislative developments in tobacco control, and the transmission of up-to-date statistics on smoking prevalence. These kinds of messages not only bring health and political information to the smoker, but will also remind her of the undeniable social trend toward non-smoking underway in Canada.

Those who subscribe to the impact of socialization and the influence of environmental factors on smoking rates, will see the importance of transmitting these types of messages. Logically, smokers will begin to understand through experience that their opportunity for, and the social acceptability of, smoking is decreasing and that the social context in which they will be able to smoke with peers, work-mates, or family is shrinking. As increasingly sophisticated health messages are transmitted, smokers will begin to see that the health costs of smoking, particularly in conjunction with aging, the use of oral conceptives, or certain environmental or occupational risk factors, indicate that there is no avoiding the message that smoking compromises women's health in increasingly dangerous ways. In addition, educational messages directed toward explaining the reasons why women smoke and linking those reasons to women's position in the social and occupational structure will serve to empower women as they begin to understand a relatively new analysis of the smoking behaviour. These educational thrusts, in conjunction with increasingly strong legislation, combine to form the societal response to women's smoking behaviour.

Traditionally, the educational response to women smokers has emphasized health messages. In particular, in the 1970's issues such as skin beauty and reproductive capability were the typical themes in

anti-smoking campaigns directed toward women. The inappropriateness of these themes has been well documented (Jacobson: 1981 and 1986, Greaves and Buist: 1986, etc.) Not only were/are such health campaigns demeaning and paternalistic, but they completely miss their target audience. Clearly, most women are not concerned about pregnancy and smoking complications and many women, especially young women, show only a passing interest in the long term effects on the skin from smoking. More recently, educational messages in the other two areas; political awareness of advertising techniques and an analysis of why women smoke, have begun to emerge. These analyses, including some feminist analyses of smoking behaviour, are serving as the pivotal points for refocussing the anti-smoking campaigns for adult women and teenage girls.

Since these thrusts are not specifically health oriented and therefore not individualistic, the messages within them concern groups larger than the smokers in the population. These more recent themes in the education messages have begun to attract the attention of the women's health movement, the women's movement and other mainstream women's groups, not only in Canada, but in other industrialized countries (Shear: 1985, Jacobson: 1986). Disease control agencies needing to market their materials to women are interested in these new educational thrusts, to make their campaigns more effective.

The decline in smoking among women as discussed in Chapter 2 has been greatest for those who are most highly educated (Millar and Wigle: 1986:130). This decline suggests that educational initiative taken so far have reached women who are more highly educated, more literate, and in occupations in which they have more control over their work. These women presumably have more disposable income with which to pursue fitness programs and to experience better nutrition and other positive health measures. In fact Mechanic and Cleary (1980), in developing an index of health behaviour, reported that women were much more likely to pursue positive health behaviours than men. However, they further concluded that the ability to pursue health reflects the ability to anticipate problems, mobilize resources and cope actively. These abilities clearly reflect the degree of social competence or control over environment that a woman may have by virtue of her class position.

Personalization of Health Messages

The development of more specific, readable materials on various health consequences of smoking for women is necessary. To be included in such materials would be the risks associated with oral conceptive use when combined with smoking, the risks of cervical cancer due to smoking and early sexual experiences, the risks to women in certain high risk occupational groupings when smoking is added to their lifestyle, the risks to pregnant women, and the risks to women with particular family histories of cardiovascular or respiratory disease etc. According to Gritz (1983:307), "more personalization of risk is necessary" with respect to creating health information. Smokers appear to be less well health-educated than non-smokers (Gritz: 1983:307), but whether largely as a result of defense mechanisms or of inaccessibility to health messages is not clear. The fact remains, however, that smokers and non-smokers alike remain ignorant of some of the more basic health facts regarding the consequences of smoking. As improving health is the primary reason for attempting to reduce smoking behaviour in women, this needs to be addressed first and foremost.

Any new health message geared toward women's smoking behaviour must avoid implying guilt or blaming the victim in any way. Further, the loading of responsibility onto the woman for the health of her partner or children is also to be avoided. Not only is this counter-productive in that it adds stress to the woman smoker, but it ignores the root reasons for the smoking behaviour and the structural barriers to cessation. The task, therefore, is to create health messages that increase the personalization of risk and widen the social responsibility for the smoking behaviour. This task represents a delicate balance.

Development of Social Responsibility

The development of new themes and alternative explanations for smoking behaviour that move the responsibility into the social realm from the personal realm seem necessary. Two examples of this would be: a) Developing accessible information explaining and exposing the exploitation of women through advertising and through manufacturers' design of certain products. A demonstration of exploitation through advertising is not difficult when presentations of advertisements, scripts, or quotes from trade journals are used. Incorporating this evidence into educational packages would seem relatively easy; b) incorporating an analysis of

why women smoke into educational materials. Although there are not definitive answers to the question of why women smoke, various aspects have been identified that could be incorporated into educational materials. The other aspects of women's experience, such as overwork, conflicting roles, job ghettoization etc., can be linked with the smoking behaviour. This approach could improve the receptivity of women to these messages as immediate defensive responses may be tempered. Similar shifts from a perceived individual to social responsibility for a situation have been made for rape victims and battered women, for example.

The development of social concern themes is necessary to attract significant political and social support to the issue of women and smoking. An honest message of concern for women's health as a human resource needs to be conveyed. Specific targeting may be necessary, i.e. to groups such as native women or young women, but the framework for these messages should outline a social responsibility for both the problem and its solution. All of these themes need to bear in mind the quote from *Achieving Health For All* by Jake Epp, Minister of Health and Welfare: a "blaming the victim attitude is based on the unrealistic notion that the individual has ultimate and complete control over life and death." (Epp: 1986:12).

Integration of Messages

The development of integrated methods and a reclamation of old educational methods that affect smoking behaviour in women is necessary. As well as developing specific campaigns targeted at various sociocultural groups of women, an attempt must be made to integrate smoking and health messages into existing educational materials and initiatives. Similar to integrating smoking and health messages into the health curriculum for school children, a serious attempt must be made to provide adult women with such messages. This effort may take some creative co-ordination with existing groups or health associations that may be primarily concerned with other issues.

For example, conferences, pamphlets or materials on drugs or drug education should no longer be considered complete without the inclusion of smoking behaviour as an issue. Women's health groups need support and co-ordination to allow them to include information and direction on women's smoking. Occupational health and safety associations, committees within unions or government departments ought to address smoking as an occupational health and safety issue. Services for victims of violence, such as battered women's shelters or clinics, need to integrate smoking dependence messages into their programming. Native associations need encouragement to begin to consider the cultural meaning of tobacco and its current implications for health behaviour. These are but a few examples of a more holistic, integrated method of education that is urgently required on this issue.

New Communication Methods

In addition, specific methods can be reclaimed or created. For example, the reclamation of advertisers' themes and techniques that have seduced women needs to be incorporated into the anti-smoking campaigns. The recent theme for National Non-Smoking Week'88 of "Taking Control" is a good example of this. The use of billboards needs to be seriously studied for the placement of pro-health messages for women. Similarly, advertisements on public transit or bus shelters need to be considered. The placement of health messages and information on women and smoking on product packages such as milk cartons or yogurt containers needs to be considered. The inclusion of a mailer stating basic facts about women and smoking and some tips on cessation in family allowance cheques needs to be investigated. These are only a few examples of how methods need to be reclaimed or invented to begin to integrate positive education messages into other aspects of the lives of women.

Diversification of Sources of Smoking Education

Related to this is the development of more diverse resources of smoking education for women. In addition to sociocultural specificity, and increasingly focused targeting, there needs to be developed a sensitivity to the impact of the *source* of the educational message. A message from a medical association will be differently received than a message from the native friendship centre, even though the contents of the message may be similar. This diversification of the sources of smoking education messages improves both the accessibility of those messages and the receptivity to those messages among the target populations. Further, it draws into the network of those agencies and organizations interested and concerned with women's smoking behaviour a wide variety of people and structures that previously were

uninvolved. This approach produces a community involvement which is more inclined to have meaning to particular target groups. Equally important, this would symbolize a community investment in reducing the problem of smoking behaviour in women. This investment is perhaps one of the best ways to send the positive message to adult women smokers that their health is a valued resource in the country and in the community, because women's health is important in itself.

A main challenge in this diversification process is to reduce territoriality and political divisions between those agencies currently concerned with the issue of smoking behaviour in women, or smoking behaviour in general. A second challenge involves convincing various community groups *not currently involved*, to apply resources or energy, however small, to the issue of smoking and women. Community groups to be approached in this task are those groups already concerned with women's health; those groups concerned with related issues, such as occupational health and safety or environmental concerns, and those associations and organizations concerned with particular target groups such as battered women's shelters, native friendship centres, particular occupational associations, etc. In short, the challenges for the development of a broader-based community response to the issue of smoking among adult women are considerable. However, experience with raising awareness of other social and environmental issues shows that once there is a broadly based community concern for an issue, accelerated positive change will occur.

C. Issues For Future Action

12. Efforts need to be made to develop a comprehensive public education campaign for women, linking the oppressive aspects of smoking, substance abuse, and the subscription to a culturally imposed ideal body image through dieting. This would include coverage of reasons for smoking, health risks for women, and advertising and manufacturing techniques designed to exploit women. Such a program could be packaged and distributed in a kit format, (similar to *It's Just Your Nerves*).

13. Consideration needs to be given to assessing the literacy levels of educational materials and to the development of material using non-print media (tape, video, film), as measures to improve the accessibility of such materials.

14. Agencies concerned with women and smoking need to place more emphasis on identifying and changing the structural pressures in women's lives that may contribute to the need to smoke.

15. Comprehensive research needs to be undertaken to establish rates of smoking and smokeless tobacco used among native women, (and men), to support efforts to develop a holistic, native-controlled smoking education program.

16. Emphasis needs to be placed on the integration of information and education on women and smoking into materials and programming of other health and community groups dealing with women.

17. Qualitative research in the area of maintenance behaviour in women should be encouraged, to develop a deeper understanding of the experiences of women smokers.

Chapter 5

A. Cessation Of Women's Smoking Behaviour

Cessation for males or females is a difficult task. Much research and planning has gone into developing cessation programs but results indicate that a lot more needs to be done. One of the major research difficulties in this area is that the samples of people studied in cessation programs per se are obviously self-selected. Estimates vary, but between 90 and 95 percent of individuals who quit smoking apparently do so without the aid of a formal cessation program (U.S. Department of Health: 1977)*. However, it is largely the remaining 10 percent who come to the attention of researchers, evaluators and program planners. This particular minority may be considerably different in a number of ways than the majority of people who appear to be able to quit smoking on their own. As a result, basing policy and program planning decisions on the experience of this 10 percent is tricky.

Sex and Cessation

An interesting fact reported by Jarvis (1984:384), is that 70 percent of the individuals who seek help in cessation programs are female. Interpretations of this might differ. Women could be more likely to want to talk in group situations about problems such as smoking, or perhaps, women do attempt to quit smoking on their own, run into trouble and consequently decide they need a cessation program for group support.

Whichever method is chosen, it seems that the long-held belief that women have more trouble quitting than men is being laid to rest. A number of British authors, in reviewing supposed sex differences in cessation rates include secondary smoking as a factor in their measurement. When this is done, men appear to have lower cessation rates than traditionally believed and the sex differences virtually disappear (Jarvis: 1984:385). Any sex differences that do remain apply only to those over the age of 50. These results are based on surveys in Great Britain and the United States and account for secondary cigar smoking only. Had consistent data on secondary pipe smoking and smokeless tobacco use been available and taken into account, it is possible the sex differences could have disappeared entirely. With respect to cigarette cessation rates per se, Jarvis (1984:385), states that "older women find it more difficult to give up smoking than do men." Even though sex differences in smoking cessation clearly depend on the wideness of the smoking definition taken into account, the important point is that with respect to cigarette smoking only older women may be a particular target group for cessation programming.

These findings in no way contradict the notion that women and men smoke for different reasons, and perhaps may quit for different reasons. Additionally, women "have different fears about quitting" according to Jacobson (1986:87).

Class and Cessation

Not only are both males and females of lower socio-economic status more likely to smoke, they are both less likely to quit (Jacobson: 1986:13). Further, in the United States, black people are less likely to quit than white people (Jacobson: 1986:13). The fact that smoking is increasingly concentrated in the lower classes, or in those who are most disadvantaged such as racial minorities and women, as compared to racial majorities or men, provides the most salient framework for studying cessation rates. The enlarged differences in smoking prevalence between various demographic groups must be understood as either a reflection of different needs to smoke (in a functional sense) or a reflection of the ineffectiveness of smoking education messages for these particular groups. In the current social and legislative climate, smoking cannot be understood as "just a pleasure". Rather, the persistence of smoking behaviour can most usefully be understood as an adaptive response to life situations. Hadaway et al (1986), detail the functional aspects of smoking behaviour. Some social-psychological adaptations include: using smoking as a way of coping with stress and problems in living; as a mode of suppressing

* The basis for this figure has not been identified. See Tunstall et al: 1985

feelings, and as a route to relaxation, concentration, weight control, social acceptance, etc. Understanding these adaptations of smokers is important for cessation programme planners.

Preparing to Quit

A study completed in the U.K. by March and Matheson (1983), contributes an important concept to cessation research. These authors state that there is a pre-cessation stage that most smokers go through, that they name variously the "faltering" or "wavering" of the habit. In short, this is a preparatory stage to quitting. Naming this stage is important, as this allows health planners and researchers to focus on measures that may affect smokers in this "wavering" stage. This stage may be lengthy, and may include various processes. Smokers entering this stage may be affected variously by legislation, education, health experiences, life changes or social supports. It is conceivable that each of these factors chips away at the smoker's identity, and produces doubts about smoking that contribute to the preparatory stage.

Jerome Schwartz (1983), while agreeing that most smokers (95 percent) quit on their own, points out that for this large majority many social, educational and medical influences have presumably had their effect. So the concept of "quitting on one's own" also refers to the process Matheson and Marsh have outlined as the wavering or the faltering stage. In short, most people who quit do so by incorporating various messages regarding the smoking habit into their behaviour without coming to the attention of official cessation programs where researchers can take note of their involvement. Two points are salient: most people utilize various types of assistance (social, medical, educational etc.) in their quitting process and they likely develop a weakening of their habit over a long period before cessation actually occurs.

Repeated Attempts to Quit

Most smokers attempt to quit at least once, while 40 percent have attempted to quit at least three times (Schwartz: 1987:15). Among those who attend cessation programs and those who do not there appear to be many attempts made, using various methodologies to either reduce or cease the smoking habit entirely. What is missing, not only in cessation programming but in the popular understanding of this process, has been tolerance for these repeated attempts to quit. Although previous attempts are one of the best indicators for future attempts (March and Matheson: 1983:132), this pattern has not been recognized as positive in many programs and in many aspects of the literature. Consequently, potential quitters or those in the "wavering" stage have often interpreted their repeated unsuccessful attempts to quit as personal failures. Greaves et al (1983), reporting on the Regina Quit-For-Life cessation program state that incorporating this view into smoking cessation programs allows participants to maintain both self-respect and intact egos.

Experimental support for the notion of redefining apparent cessation failures as accomplishments exists in Coelho's (1984) study on self-efficacy and smoking cessation. He concludes that "mere participation in a smoking-cessation clinic served to strengthen personal efficacy, even for those who continued to smoke or relapsed". (1984:310) Such experiences alter expectations about future success, in addition to effecting short-term success. Although Coelho studied a mixed sample, he unfortunately did not distinguish between males and females in his results. As gender is a potentially weightier variable than smoking history, social support, or a host of others, all future research should automatically distinguish results by gender, and if possible, by class.

According to the March and Matheson survey done in the United Kingdom, 53 percent of ex-smokers found giving up "not at all difficult" (1983:128). Even though most ex-smokers in the study had a long list of earlier attempts, the actual experience of giving up remained manageable for the majority. As smoking cessation is widely perceived as a difficult or somewhat impossible task, this is an interesting and important finding.

Behavioural Intentions

The March and Matheson study attempted to measure "behavioural intentions", or the aspects of behaviour intervening between attitudes favouring non-smoking and subsequent quitting behaviour. These behavioural intentions are characterized as "the desire, intention and confidence to carry on, cut down or give up smoking" (Marsh and Matheson: 1983:127). Women smokers were slightly less likely to be confident and reported more stress than male smokers. (Similarly, female non-smokers reported more stress than male non-smokers.) While stress depresses a smoker's confidence in giving up, it enhances the desire and

resolution to do so. The important conclusion is that stress is not a barrier to giving up. These reported differences in stress between men and women and between smokers and non-smokers, however, are so slight that support for the general thesis that stress-related smoking is more characteristic of women than men eludes these two authors. Another important detail with respect to women smokers is that potential quitters, even if suffering low self-esteem, perceive that the act of quitting would bring greater self-esteem to them.

While social influences (e.g. the number of smokers in the environment) in this particular study had limited effect on peoples' desire or resolve to give up smoking, nor did potential social gains have an impact on the confidence to quit. This is an interesting finding with respect to women. Emphasizing social gains, such as

Table 23
SUMMARY OF FOLLOW-UP QUIT RATES OF 416 SMOKING CESSATION TRIALS BY METHOD
Reported 1959-1985

Intervention Method	At Least 6-Month Follow-Up				At Least 1-Year Follow-Up			
	Number	Range	Median	Percentage 33%	Number	Range	Median	Percentage 33%
Self-Help	11	0–33	17	18	7	12–33	18	14
Educational	7	13–50	36	71	12	15–55	25	25
Five-Day Plan	4	11–23	15	0	14	16–40	26	21
Group*	15	0–54	24	20	31	5–71	28	39
Medication	7	0–47	18	14	12	6–50	18.5	17
Nicotine Chewing Gum	3	17–33	23	33	9	8–38	1*	11
Nicotine Chewing Gum and Behavioural Treatment or Therapy	3	23–50	35	67	11	12–49	29	36
Hypnosis — Individual	11	0–60	25	36	8	13–68	19.5	38
Hypnosis — Group	10	8–68	34	50	2	14–88	–	50
Acupuncture	7	5–61	18	29	6	8–32	27	0
Physician Advice or Counseling	3	5–12	5	0	12	3–13	6	0
Physician Intervention — More Than Counseling	3	23–40	29	33	10	13–38	22.5	20
Physician Intervention								
— Pulmonary Patients	10	10–51	24	20	6	25–76	31.5	50
— Cardiac Patients	5	21–69	44	80	16	11–73	43	63
Risk Factor	–	–	–	–	7	12–46	31	43
Rapid Smoking	12	7–62	25.5	33	6	6–40	21	17
Rapid Smoking and Other Procedures	21	8–67	38	57	10	7–52	30.5	50
Satiation Smoking+	11	14–76	38	64	12	18–63	34.5	58
Regular-Paced Aversive Smoking+	13	0–56	29	31	3	20–39	26	33
Nicotine Fading+	7	26–46	27	29	16	7–46	25	44
Contingency Contracting+	9	25–76	46	89	4	14–38	27	25
Multiple Programs+	13	18–52	32	38	17	6–76	40	65

*Three group trials has 5-month follow-ups

+Other procedures may have been used and some trials may be included in more than one method.

Note: Percentage 33% is percent of trials with quit rates of at least 33 percent. Median not calculated for less than three trials. Caution: quit rates provided suggest overall trends. Most quit rates were based on self-reports. Some quit rates were re-calculated to include all subjects, but most quit rates were based on reports by investigators. Some quit rates omitted subjects who did not complete treatment or persons who did not reply to follow-ups. Definition of follow-up may vary between trials.

one's potential role modeling ability to a child or the possibility of improving the way other people think of you, is relatively ineffectual with respect to improving a woman's confidence level in her ability to quit.

Overall, the younger smokers had more positive attitudes toward the consequences of giving up and in this particular study, young women stood out in their positivity about the benefits of not smoking. This could explain the difficulties of older women in smoking cessation mentioned in the earlier review of sex differences in smoking cessation levels. In order of priority, the attitudes that have the most effect on the process of preparing to quit smoking are thoughts of positive health benefits, economic benefits, and greater self-esteem. Finally, a high stress level combined with some confidence indicates an acceleration of the process of deciding not to smoke. "Neither stress nor a record of past failure inhibits the resolve to give up, but actually increases the likelihood that further attempts will be made." (Matheson and March: 1983:132).

Not covered in this particular study is an exploration of how high stress may contribute to the development of resolve. This is a crucial area that needs some investigation as both smoking and non-smoking women do report higher stress in their lives than do men. Clearly, concentration needs to be maintained on young women smokers as they remain more confident as to the consequences of quitting. Similarly, de-emphasizing the social gains of quitting might be in order if we are interested in improving confidence, a particular concern for women in the wavering stage of smoking.

Reinforcing Attempts to Quit

The principles outlined above in the U.K. study must be further explored as concentration on affecting the wavering or preparatory stage of the smoking habit in adult women is in order. Much of the treatment and smoking education currently in place is directed at this stage, whether or not this is made explicit. Some thought needs to be given to the possible consequences of naming this stage and beginning to form smoking education around the label. This may serve as an educational framework for communicating that preparing to quit is (potentially) a long process, that it involves certain components or behavioural intentions, and that those behavioural intentions may indicate some false starts or attempts at quitting that are a positive part of the process. Developing an educational frame work around this stage may allow for specific programs directed at enhancing issues of confidence, resolve and desire among smokers. The de-emphasizing of external influences such as social and economic gains, and the re-emphasizing of the value of the individual gains would be part of this thrust.

For women, these individual gains include improving "social competence", self confidence, or self-esteem, and internalizing the locus of control. Presumably, if young girls and women feel more in control of their lives, their situation in life, and of the events that happen in their lives, smoking prevalence would be reduced. Obviously, systemic structural changes need to be made to allow girls and women to truly believe that they have more control over their destiny, but it is also possible that an interaction between negative habits, such as smoking and psychological outlook, could exist.

Cessation Methods

Although it is widely believed that most smokers want to quit and most quitters do so on their own (Schwartz: 1987), doing so on one's own in fact involves a response to a number of different cessation influences such as a physician's advice, a self-help manual, a pamphlet from a health organization, a fear film, or a personal health scare. This result is important, indicating that cessation materials and methods, even though commonly assumed to apply to the less than 10 percent of the smoking population that appears at formal cessation programs, obviously affect a much larger portion of the smoking population. The actual figure, of course, is unknown, but it can be assumed that any education, information about treatment programs, or publicity about aspects of smoking behaviour and treatment has an effect on both the general understanding of the problem and the creation of ambivalence in current smokers. Even so, very little research has been done on people who quit smoking on their own. It remains difficult to establish what characteristics self-changers have compared to those smokers who appear at cessation programs. This is an important area of investigation, as it would shed light on which qualities might be encouraged in smokers in the faltering or preparatory stage. It may also shed light on which changes in social supports or systems may be favourable to self-changing the smoking behaviour.

Although, *Smoking Cessation Methods* by Jerome Schwartz (1987) is the most comprehensive review and evaluation of cessation in North America, there is no direct attention paid to issues relevant to women, with the exception of a short chapter on the effects of smoking on pregnancy and an evaluation of pregnancy quit programs. In the summary, young women are highlighted as a target group in need of special attention with respect to cessation. The perspective in this review does not include the questions about gender that are pertinent to the issue of women in smoking and women in cessation. This may be because there are no particular women's cessation programs to be studied and evaluated. It could be expected that a review of this comprehensiveness would have found any women's cessation programs that do exist in the United States. This omission is striking evidence of the lack of attention that has been paid to women smokers.

Schwatz's book, however, is extremely valuable in categorizing cessation methods and summarizing the evaluations of those methods in Canada and the United States over the last eight years.*

No attempt will be made to replicate this work with respect to Canada, other than to refer readers to this source. However, various categorizations, comments and conclusions drawn by Schwartz in this comprehensive summary will be highlighted as they may apply to improving cessation services to women smokers.

The ten main types of cessation programs covered are:

1. Self-Care
2. Educational Approaches (including clinics and groups)
3. Medication
4. Nicotine Chewing Gum
5. Hypnosis
6. Acupuncture
7. Physician Counselling
8. Risk Factor Preventive Trials
9. Mass Media and Community Programs, and
10. Behavioural Methods

In addition, particular attention is paid to worksite smoking policies and programs, reflecting the observation of Schwartz that the majority of the adult smoking population can be accessed through the workplace. Finally, issues regarding maintenance and prevention of relapse are considered by Schwartz.

Evaluation Problems

The field of cessation evaluation is characterised by inconsistency and a complete lack of evaluation attached to certain programs. This fact is a major methodological problem in assessing cessation. Cessation programs in most categories achieve fairly high success rates at the end of the program, ranging from 50 to 80 percent. However, the long-term success rates, measured anywhere from 6 to 12 months later, are obviously somewhat lower. Commercial cessation clinics, in particular, often do not reveal their evaluations. Many cessation programs designed on slim resources do not include an evaluation component. There are significant problems, therefore, in understanding cessation efficacy. Although an informal code for measuring success in cessation implies abstention from all forms of tobacco for one year following treatment, Schwartz indicates that an absence of a recommendation for biochemical validation of self-reported cessation is a severe deficiency in the code. He also notes that the code is not followed by many cessation programs.

Something for Women

Four particular conditions improve success in cessation, according to Schwartz (1987:7).

1. Multiple cessation methods that deal with different types of people or different uses of smoking cigarettes.
2. Payment to intensify commitment.
3. Presence of personal health risk factors.

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* See Table 23, from Schwartz, J. *Smoking Cessation Methods*, 1987.

4. Maintenance procedures which support ex-smokers.

The first point echos the American Lung Association's position that cessation programs must have "something for everyone" in them (A.L.A.: 1983:155). It also supports the idea that different groups of smokers (men, women, blue collar workers, etc.), who smoke for different purposes, benefit from different cessation methods. This is a clear argument for developing specific cessation programmes and materials, to better target or segment the smoking population. Such materials could be used in either integrated or segregated settings to good effect.

Incentives for Women?

Payment as an intensifier of motivation with respect to women is of questionable value. More work needs to be done to establish how motivating payment is. It is noteworthy that the Smokefree program directed toward women only in Toronto, Ontario charges a $25.00 per session fee, but offers a sliding scale and a delayed payment plan (Cole: 1986:6). This kind of sensitivity to women's economic status is advisable, but there is no doubt that even a nominal fee is a barrier to cessation for many women.

"Payment to intensify commitment" may work in the opposite direction, however. An interesting public cessation program reported by Glasgow et al (1985), is the "stop smoking contest". Prizes were offered for verifiable smoking cessation. Although intuitively one would expect more men than women to be attracted to a fundamentally competitive model, more women than men entered the contest. Perhaps this model is attractive to women for other reasons, including perceived concrete reward. The important result of this study, however, indicates that sex had no effect on success among this group of smokers attempting to quit on their own (Glasgow et al: 1985: 909). Perceived stress was the strongest predictor of failure or success in smoking cessation. Although this study did not explicitly investigate sex differences, it is an important study in investigating the large group of smokers who attempt to quit on their own. Much more work is to be done to establish what particular mechanisms successful quitters use. One finding emanating from Glasgow et al is that successful self-quitters more likely use self-rewards than self-punishments in their process. This finding is important with respect to cessation, and offers support for the notion of avoiding negative messages in developing supportive materials for self-quitters.

"Healthy" Smoking?

The presence of health risk factors clearly has an influence on cessation when observing success rates of physician intervention with cardiac patients. Thought must be given to producing health risk information that will impress young women. Possibilities include developing specific thrusts on the combination of oral contraceptives and smoking, and on the cervical cancer risk. Although the shock tactics of showing damaged lungs that were popular in former decades have been largely abandoned, it is possible that after adequate research on the possible counter-productivity of fear communication, some equally dramatic evidence needs to be presented to women on newer health risks such as cervical cancer.

An interesting detail in cessation success reports that is pertinent to women's perception of health risk surround the issue of the use of low or high-nicotine cigarettes. Men are more likely to use high strength cigarettes than women. In 1979, 39 percent of women smokers and 28 percent of men smokers in the United States used low-strength cigarettes (U.S. Department of Health: 1980). Studies in predicting successful smoking cessation have found that those smoking higher nicotine cigarettes are more likely to quit than those smoking lower nicotine cigarettes. Stevens et al (1982), suggest that those smoking low-nicotine cigarettes perceived that such activity was less of a health threat and therefore were not as highly motivated to attempt cessation. Additionally, Stevens et al suggest that those smoking higher strength cigarettes may have experienced more negative health consequences, also increasing their motivation to quit.

Wilson et al (1982), in a Hamilton, Ontario study, found that patients smoking regular tar cigarettes were more likely to quit than those smoking low tar cigarettes. Miller (1985:316), concludes that the "less hazardous" cigarette, is a "deadly delusion", and a "hypothetical construct". Clearly, an assessment is needed of the effects of smoking the "healthier" cigarettes on women's motivation and success in quitting. Although Stevens et al (1982), conclude that the interaction between nicotine levels and quitting is complicated, new knowledge in this area may lead to additional clarification in health

information for women exposed to the dangers of low tar and low nicotine cigarettes.

Wider Social Support

Gaining support from the non-smoker or former smoker is clearly an important variable for women. Many women report that partner support is crucial to their success in cessation and to their success in maintaining their status as a ex-smoker. Additionally, the creation of social support in the workplace and the elimination of cues for smoking in the smoker's environment, are factors favouring the maintenance of cessation behaviour. Maintenance programs must be tailored specifically to women. An assessment and identification of high risk social situations with respect to relapse must be made. The effect of advertising after smoking cessation and the development of coping strategies for preventing negative life events from contributing to relapse needs more investigation. These areas are largely unresearched and need attention from the perspective of the woman ex-smoker.

In the area of social support, the involvement of non-smokers could facilitate the maintenance of the ex-smoking status. In a study by Coppotelli and Orleans (1985:458), partner support for newly quit married women smokers was the primary predictor of maintenance of the ex-smoker status. Non-smokers in the immediate circle of the ex-smoker are clearly to be targeted, but also the non-smokers in the community at large need more development as a potential support group for ex-smokers. Aspects of the Great American Smokeout, a program of the American Cancer Society, illustrate this concept, as non-smokers are pressed to show tolerance and support to the smoker (Valpy: 1987).

A recent study by Evans and Lowe (1986) studied the differences in attitude and beliefs about cigarette smoking between men and women. Male non-smokers were accurate in their perceptions of both male and female smoking behaviour, while female non-smokers were inaccurate in their perceptions of why women smoke. Although the smokers in the sample reported predictable sex differences in reasons for smoking (women cited negative affect as a principal reason for smoking) the male non-smokers exhibited a more comprehensive understanding of these differences than the non-smoking women. As Evans and Lowe conclude, if non-smoking women are to be included in programs designed to assist smokers in quitting, effective education needs to be created and directed toward the non-smoking woman to correct these misperceptions. Evans and Lowe suggest that public education can mobilize the attitudes of non-smoking women by orienting campaigns toward the difficulty of quitting, rather than the health consequences of cessation. This thrust would increase public sympathy for the smoker, thereby defusing the conflict model that so often invades the smoker/non-smoker relationship. An unintended or adverse consequence of this approach, though, could be the increasing propensity of smokers to admit defeat because of the heightened awareness about cessation difficulty. This approach could adversely affect the development of confidence in quitting in women.

Support for health care professional cannot be undervalued. When a physician or other health care worker makes a statement or offers encouragement regarding smoking cessation, the effects are marked on the smoker. Schwartz (1987:56) reports a quit rate of 6 percent following simple physician counselling.

Focus On Women

After reviewing the cessation literature, it must be concluded that *all* cessation program planning and evaluation thereof should, in future, be attentive to gender. At this point in the study of smoking behaviour, any evaluation that does not specify gender in its measurement or conclusions is relatively useless in informing strategic planning. For example, it is known that physician intervention with cardiac patients brings high cessation results (Pederson: 1982, Schwartz: 1987), but sex differences in this group are unknown. In measuring the effectiveness of group programs, it is important to know what aspects of the program may affect women and men differently. These factors could be as simple as the time of day when the group meets, the gender of the leader, or the accessibility of the group with respect to transportation, child care, or incentive fee. Smoking research in general, but in particular cessation research, needs more qualitative data gathering. The determination of the meaning of smoking for women and consequently the determination of factors that would assist women in quitting smoking, can often best be derived from listening to the experience of women in their self-descriptions. In this kind of material (some of which is included in Jacobson's 1986 and 1981 books, vital clues arise for

research and analysis that do not arise solely from the study of quantitative data.

Finally, although many authors quote a 90 to 95 percent self-quitting rate, as recently as 1985, Tunstall et al, in a survey of the literature of quitting smoking, were forced to conclude that the basis for this figure is not identifiable. The figure is quoted as early as 1977 in United States Department of Health publications, and has clearly become current since. No comparable figure exists for Canada, with or without identifiable sources. Not only does this American figure need an empirical base – efforts should be made to establish an empirical base in Canada. Specific efforts should be made to establish differences in self-quitting rates between men and women.

B. Education And Treatment Issues In Women's Smoking Cessation

Woman-Specific Programming

In learning from methods used in the women's movement and in women's groups, it seems that establishing women-specific education and treatment programs for smokers would yield interesting qualitative data, valuable case studies and valuable opportunities for consciousness-raising and sharing among women smokers. Many of the needs women exhibit both as smokers, potential quitters, and as ex-smokers may be met in this context. Although the re-design of many programs and curricula is necessary, short term improvements in the delivery of cessation and educational treatment programs could be made by simply segregating the clients. This could be accomplished at very low cost. Coupled with the provision of female leaders for such groups, an immediate improvement may be seen in eliciting positive change behaviour among women smokers. Many cessation group leaders working with both men and women smokers report that differences emerge in the conduct of men and women in cessation groups. Women appear to need a different level of discussion about elements of their dependency. This apparent need reflects the different reasons for smoking and quitting that women may hold. Although there is little clear research on which to base this recommendation, there is no reason to delay in establishing such groups in order to build such a research base and to complete proper evaluation. In mixed groups of any kind, it has been reported that men often dominate, by determining not only the topic to be discussed, but also the structure and parameters of the discussion (Spender: 1980:46-7). In woman-only groups, women could develop confidence in quitting and a sense of increased personal power and control over life: two key elements in successful cessation.

Accessibility

Easy access to all educational materials and cessation groups in critical. Accessibility is a concept that is only narrowly understood. Literacy level, child care availability, sliding scale or no fees, and geographical location are but a few of the accessibility issues for women. If a woman feels for any reason that an educational program, a piece of advertising or a cessation group does not speak to her needs, her life style or her value system, then such offerings are inaccessible. This type of accessibility can be improved or created through direct consultation with target groups. For example, testing the text or asking for comments on illustrations and photographs used in a "stop smoking" publication with a group of sole support, low-income mothers would give valuable insight into the creation of such materials. Checking program content with groups of native women would not only increase the efficacy and accessibility of such programming, but would also raise consciousness in the process.

Positive Reward for Women

In general, cessation education and programming must begin to focus on positive behaviours and to create opportunities for the positive reinforcement of any quitting attempt in smokers. Positive reinforcement for questioning the smoking habit, or entering into the faltering stage of smoking behaviour, needs to be integrated into educational and cessation materials. Specific examples include reinforcing quitting attempts, re-defining relapse as predictable and progressive (as opposed to failure), and educating people on the cyclical nature of cessation-relapse-cessation behaviour.

Ellen Gritz (1987:19), suggests that more concentration is necessary "on replacing the rewards of smoking with other rewards". If women smoke for reasons such as gaining a ten-minute break, weight management, or to relieve stress, cessation education needs to direct its programming to replacing those rewards with others.

Guilt-Free Cessation

To offer current smokers an obstacle-free cessation program, a general "amnesty" program for smokers could be publicized and carried out across the country. This activity would incorporate a free, accessible workplace or community cessation program for a period of three years. During such an "amnesty" period, a smoker could commit to a cessation program with no fee attached, with a sense of community support, and possibly with time allowed in the workplace for pursuing such a program. Employers could be convinced of the economic utility of such support as non-smokers would acquire better health, be less distracted and more safe on the job. A pilot smokers' "amnesty" program could be tested in the federal public service or in a provincial public service, to establish procedures and measurement standards. Accurate self-reporting of smoking status and good evaluation of the health and economic benefits accrued would be necessary to gain widespread employer and community support. The amnesty concept carries with it a connotation that it would implicitly involve the entire community in support of smokers availing themselves of such opportunities. Whether this idea gains widespread support or not, individual companies, communities or institutions could institute such programs.

Integration of Efforts

The last general principle in providing a cessation/treatment program is that all future efforts in Canada need to be integrated into a rational, planned policy. This principle of integration needs to be evident not only at the community level, but also at regional and national levels. Integration means that multi-disciplinary and diverse groups will be co-ordinated in the planning and evaluating of such programs with the consequence that all interested groups in the community will have both input and ownership. Second, integrated programs are more easily evaluated, which means that research and future planning will be more easily carried out in this very crucial area of smoking education. Finally, the consumer of such education and cessation treatment programming will be more likely to experience a co-ordinated approach to her problem, less likely to encounter conflicting advice or contradictory evidence, and consequently feel more secure in the cessation process.

C. Issues For Future Action

18. Consideration needs to be given to naming and popularizing the preparatory stage, and developing educational materials around this stage.

19. An increased emphasis on the predictability of the cessation-relapse-cessation cycle, and the redefinition of repeated quit attempts as gains, needs to be made.

20. Increased effort needs to be placed on mobilizing, recruiting and educating non-smokers (particularly women) to support women smokers.

21. Program planning, content and evaluation needs to be re-evaluated from a women's perspective, and consideration given to segregating women smokers for cessation program purposes.

22. Research emphasis needs placing on self-quitters, and the male/female differences in self-quitting.

23. A national co-ordinating committee on women and tobacco needs to be established to become the central point for collecting information and co-ordinating activity in research, program development, health and education.

Chapter 6

A. Two Specific Target Groups For Cessation

In this chapter, two very different sub-groups of women smokers are briefly examined: pregnant smokers, and battered women who are smokers.

The pregnant smoker has perhaps, been over-emphasized in health education campaigns and research programs over the last twenty-five years. Considerable criticism has been levelled at the smoking and health community for this over-emphasis, to the exclusion of other important, women-focussed work in the effort to reduce smoking (Jacobson: 1981, 1986). The fetus-centredness of the activities, and the resultant stress on the threats to the reproductive capability on women, not only angered many women analysts in the 1970s and 1980s, but more importantly, caused the education efforts to have a reduced impact.

On the other hand, the battered woman smoker has been ignored in smoking and health literature. No groups of victims of violence have been assessed with respect to smoking behaviour. Even though there are likely more battered women than pregnant women in Canada at any given time, this characteristic has not, so far, been researched.

There are many other target groups of woman smokers needing attention, but these two are presented here as, a) a group needing fresh attention (pregnant smokers) and b) a group needing any attention (battered women smokers).

B. The Pregnant Smoker

Pregnant smokers offer a challenging case for health workers. The issue of pregnancy and smoking has received limited treatment in this background paper, because of the extensive treatment this target group has received in the past. The concerns of people interest in women and smoking have often focussed almost exclusively on the issue of pregnancy. The view of women as "receptacles for future generations" (Jacobson: 1986:124), has often been the orientation when analyzing, researching, or making recommendations about smoking prevalence in women.

Currently, this extremely important health issue for women is beginning to be placed in proper perspective. As Jacobson (1986:125), states, "a campaign directed solely at smoking in pregnancy ignores most women most of the time". She goes on to say that "the way to deal with smoking in pregnancy ... is in the context of other relevant aspects of pregnancy and a woman's life as a whole". (1986:125)

According to British and American surveys of pregnant smokers, those most at risk are black, working class, and undernourished women (cited in Jacobson: 1986). Although smoking is hazardous to the health of pregnant women and their unborn babies, the interaction of social factors with smoking and pregnancy produces the highest risk.

A survey of 3600 postpartum women in Ottawa, conducted in 1983, revealed that 61.1 percent of the pregnant women smokers changed their habit in some way, while pregnant. (Stewart and Dunkley: 1985) Those most likely to quit in the first trimester of pregnancy were of the higher income level, married as opposed to single or living common law, and older. The poorest women in the sample were most likely to smoke. (Stewart and Dunkley: 1985: 992)

Langford et al (1983), report that three quarters of pregnant women attending prenatal classes experienced smoking reduction or cessation. In measuring the impact of smoking education in the prenatal class, it was clear that, at one year follow-up, the percentage of non-smokers was higher among those who had received the program than those who hadn't. (1983: 287) As this educational program was offered in the seventh month of pregnancy, many women felt that they could not benefit. In fact, the unintended consequence of offering the program at this point was to increase the level of cognitive dissonance and therefore guilt, in the women, with respect to their smoking habit. (1983:288) These authors note, however, that a delayed response to the smoking education program may have caused part of the reduction in smoking

prevalence measured a year later in the women. Langford et al suggest a "continuum of non-smoking behaviours" be suggested to pregnant women, rather than focussing exclusively on quitting. (1983:289).

Kaetz et al (1983) reported on smoking support groups set up in rural Nova Scotia for pregnant women. Twenty-five percent of those women completing the program stopped smoking and twenty-five percent reduced their smoking. However, many problems in using support groups to influence pregnant women in smoking cessation were demonstrated. Health information about danger to the fetus was not motivating. Rural Nova Scotia was a difficult area to penetrate with media, health care professionals and educational programs. Transportation was difficult to arrange in thinly populated areas; a high attrition rate resulted, and the group process was compromised by this. Considering this support group system had been set up on request of many smokers in the area, it was surprising and disappointing that only 11 percent of those requesting the support groups accepted the program. This study illustrates clearly the complex interaction of factors such as class, rural living, and health awareness that influence cessation rates in any population.

A progressive look at pregnancy and smoking is included in a study on lifestyle by Bryce and Enkin (1984). In discussing the impact of advice given to pregnant women with respect to smoking, these authors question whether the adverse effects of anti-smoking advice, unaccompanied by social support, justify this type of health intervention. Stressing the possible functional aspects of women smoking in coping with the stress of pregnancy, Bryce and Enkin question the appropriateness and utility of giving lifestyle advice to pregnant women. Advice on its own has little effect on altering behaviour, and advice given without social support may in fact produce guilt and other counter-productive responses: "For us to seize on the vulnerable time of pregnancy as a moment to induce lifetime changes at the expense of possible lifetime guilt seems cruel indeed". (Bryce and Enkin: 1984:2129). Although pregnant women need as much health information as possible, and given that physician advice is intervention in itself, anti-smoking messages sent through physicians or other routes to the pregnant women need to be contextualized. Further consideration needs to be given to the possible negative consequences of stressing smoking cessation to pregnant women.

Clearly the smoking behaviour of the pregnant woman is linked to many other aspects of her social and psychological life. To effect permanent lifestyle change, many of these factors need to be addressed. While transmitting pertinent health information, awareness needs to be raised among health professionals and educators with regard to the unintended consequences of transmitting such education to pregnant smokers. Concentration of changing other aspects of the women's life situation may more productively affect a woman's health and well-being and the health of her unborn children.

As Ellen Gritz (1987), points out, the problems are not with white middle class women. The resistant populations to anti-smoking messages in pregnancy are low-income and teenage women, and those women who have more immediate survival problems. Clearly, innovative programming in this area and the destruction of guilt-inducing programs for pregnant women is long over due.

C. The Battered Woman Smoker

An information survey of all the residents of the battered women's shelter in London, Ontario in the month of September, 1987 was undertaken in an attempt to establish some basic information about smoking prevalence among this group. Sixteen women completed the survey, and of those, 69 percent were smokers and 31 percent were non-smokers. Ninety-four percent of these women smoked more than one pack per day, and 31 per cent reported that during their stay at the crisis shelter their smoking had increased. (Greaves: 1987).

These women had sought shelter at the battered women's home as a result of a battering incident in the home. Most had children, and most were clearly facing a "negative life event", or a point in their lives when change would have to be made. Some of them will return to their batterers and some will not. Even a complete sample of residents in battered women's shelters would not represent battered women in general. In fact, such a sample would potentially represent only 11 percent of all battered women in

Canada. (Greaves: 1987). Even so, these women represent a group who are experiencing high anxiety, stress, physical injuries, and a test of their self-confidence as they face a major life decision. Further, after a series of cycles of violence, typical of the battering phenomenon, the women's locus of control is external, and her self-esteem, low.

After entering a battered women's shelter, the high smoking rates among the women create a social situation conductive to either maintaining or increasing the consumption of cigarettes. Phyllis Jensen, the co-ordinator of Smokefree in Toronto, (a feminist women's cessation program), notes that the resistant 20 percent of women in her program, who at the program's end have not reduced or quit smoking, are often victims of violence (either battering, rape, child sexual assault, or incest). It seems logical that women in such situations will not only be more prone to initiating smoking behaviour but will be less prone to successful cessation. Given that battered women in shelters are likely to be of a lower socioeconomic status than the general population of battered women, class differences also play a part in creating these results.

The key characteristics of battered women include learned helplessness, low self-esteem, sense of isolation, low confidence, and high anxiety. In the interests of reducing the stress on battered women in crisis, most shelters do not restrict smoking. This notion is often applied to groups under stress (poor, welfare recipients etc.) with the result that the disadvantaged and those in crisis remain deprived of smoke-free zones, health education, and opportunities for gaining control of their health through choosing not to smoke. This misplaced benevolence needs to be reviewed by crisis workers. While such "non-intervention" is seen as stress-reducing, it seems that smoking norms for the disadvantaged and those in crisis are consequently allowed to lag behind those in the general population.

More investigation into such sub-groups of the population of women smokers is necessary to clarify and identify social and psychological facts that affect specific kinds of women with respect to smoking prevalence. In addition, efforts directed toward revising workers' attitudes with respect to smoking among the disadvantaged and those in crisis need to be made.

D. Issues For Future Action

24. Data-gathering regarding women's smoking behaviour needs to be integrated into other surveys or studies of groups such as native women, old women, battered women, low-income women, incarcerated women, immigrant women, black women, etc., and of other behavioural issues such as drug and alcohol dependence, fitness behaviour, eating behaviour, health care, etc.

25. Consideration needs to be given to designing positive, productive intervention programs for pregnant smokers, using qualitative data from pregnant smokers as a basis for such design, and addressing the "survival" issues of housing, under-nourishment and poverty that produce negative results in pregnancy.

26. Specific attention (in education and treatment) needs to be paid to groups of women, such as low-income women, incarcerated women, or victims of violence who may display social and psychological characteristics increasing their susceptibility to smoking and resistance to quitting, and that efforts be made to educate workers dealing with such groups on the links between empowerment and health.

Chapter 7

A. The Resumption Of Women's Smoking Behaviour

The resumption of smoking behaviour after successful cessation is fairly common. Success rates in cessation programs can be as high as 80 to 100 percent at graduation but at the one year follow-up point a 33 percent quit rate is considered good. (Schwartz: 1987). Although some multi-media campaigns and self-help guides have been evaluated, the majority of smokers who quit on their own elude study. The general finding in self-quitting studies, however, is a 20 percent success rate at the one-year follow-up. (Schwartz: 1987:20).

Although Schwartz does a comprehensive review of the knowledge regarding maintenance support and relapse behaviour, no specific attention is paid to women. The factors related to relapse among both men and women include both psychological and social factors: anxiety, stress, weight gain, lack of confidence and being around friends and relatives who smoke. Specific research needs to be done relating relapse factors to gender.

An interesting study by Gunn and Shapiro (1985), reveals that although weight gain was reported by most of the subjects, it was not a significant reason given for the resumption of the smoking behaviour. Most of the relapsers mentioned stress as a factor in resuming, even though most had not experienced dramatic negative life events.

In a study of quitting smoking by Tunstall et al (1985: 1104), a four-year follow-up of Smokenders, (a commercial cessation program), revealed 57 percent of male graduates and 30 percent of female graduates were non-smoking. These authors conclude that specific strategies regarding relapse need to be developed for women.

Motivation is often an important predictor of success in a smoking cessation effort. Tunstall et al informally measured motivation using four interesting criteria:

1. whether clients are willing to make large rearrangements in their schedules to attend sessions;
2. how consistently they attend;
3. the degree of guilt initially experienced if they relapse, and
4. the expressed determination to quit (1985:1098).

On every one of these measures, women would fare less well than men due to both psycholcgical and sociological constraints. The consistency of attendance depends on one's personal freedom and flexibility and the ability to put one's own health and needs ahead of others'. This ability is neither particularly easy to develop, nor encouraged, for women.

Relapse rates are high for both males and females, but limited research suggests that relapse rates are more serious for women than for men. This finding reinforces the need to educate potential quitters about the predictability of repeated attempts. Although this kind of education may set up a self-fulfilling prophecy, this route may more realistically prepare smokers, increase self-efficacy and develop confidence in ultimately being able to quit. Clearly, more work with a gender analysis needs to be undertaken in this area. The results of such work would have a direct impact on the creation of cessation programs, educational materials, (including self-help), and of a heightened public awareness regarding the nature of the quitting process.

B. Issue For Future Action

27. Sex-specific research and evaluation needs to be carried out to establish the differences in male and female relapse behaviour, with a view to developing specific strategies for women experiencing the cycle of relapse-cessation-relapse.

Chapter 8

A. The Current Response To Women And Smoking In Canada

The Canadian Council of Smoking and Health, established in 1974, offers a co-ordinating function to the Interagency Councils in the regions, an advocacy function for tobacco control legislation, and a research/education function. A focus on the specific issue of women and smoking has not been taken until very recently. A 1987 workshop, "Women and Smoking", in preparation for National Non-Smoking Week, 1988, was evidence of an increased interest in the issue. This organization, like many mainstream agencies working on tobacco-related issues, needs to consciously reorient its perspective on smoking and on women. This reorientation is best accomplished by remaining open to new ideas and co-operative links with other groups in the wider community.

The National Program to Reduce Tobacco Use, in establishing a working group on Women and Tobacco, is evidence of an encouraging trend in confronting the issue of women and smoking. This program, in publishing its directional paper, has identified women and smoking as a particular issue to be studied. (1987:8).

In general, the attention paid to this issue in the past has been relatively unfocussed, sometimes misdirected, and not always effective. Although there is no shortage of research on some aspects, i.e. pregnant smokers, there has been no coherent woman-centred approach taken in Canada to date. One initiative in this area is the booklet *Leaving the Pack Behind*, produced by the Province of Alberta, which provides an introduction to the issue of women and smoking. There is reason to believe that such an approach is building, however. Much work is needed to co-ordinate such action, but indications of co-operation and interest are apparent.

B. Disease Control Agencies

In informal discussions with the three major disease control organizations in Canada (Appendix B) that deal with smoking behaviour (the Canadian Heart Foundation, the Canadian Cancer Society, and the Canadian Lung Association), it becomes clear that to differing extents all three organizations are open to and seeking direction in the area of women and tobacco. There is genuine enthusiasm and a genuine concern with the issue. The entire issue of smoking behaviour among Canadians is obviously of prime concern to all three agencies. However, targeting women smokers as a specific group in need of specific attention has not yet been done.

This particular focus, although seen as important, critical, or perhaps as a future priority, is not in operation due to a lack of specific knowledge or direction. Within the Canadian Cancer Society, for example, there is a future intention of targeting women's smoking, but only after national directions have been set by the National Program to Reduce Tobacco Use. In all agencies of this nature, resources are limited, volunteers are heavily used to raise funds or carry out the actual work in the programs, and therefore specific and wise decisions have to be made about long-term priority planning.

In the Canadian Lung Association, for example, the thrusts with respect to women smokers have included the production of pamphlets on smoking for pregnant women, and a pamphlet called *Stop Smoking, Stay Trim* which is directed at women. With the exception of the Manitoba Lung Association, no specific cessation programming for women has been undertaken. With respect to the success rates of the Lung Association's cessation programs "Freedom From Smoking" and "Freedom From Smoking in Twenty Days", no particular sex differences have yet been measured.* So although it is acknowledged that women may be a particular target group, no specialized programs have been

* Evaluation is currently underway in Ontario by the Addicition Research Foundation of Ontario.

created at this point. In the opinion of a Lung Association cessation program volunteer teacher in London/Middlesex, women are somewhat 'keener' to take part in the group, more diet conscious and much more interested in an overall fitness orientation than are men. Furthermore, she felt that women are much more inclined to talk in a more open fashion about the details of their lives than are men. With respect to the difficulty smokers have in maintaining their resolve through a cessation program, women are much more likely to be affected by a lack of partner support. In certain situations it is recognized that a smoker remaining in the family, (i.e. the partner of the smoker attempting to quit), feels threatened by the emerging non-smoker. This particular complaint is mostly heard from women. This lack of support for women needs considerably more study. The emerging non-smoker, whether male or female, is somebody who is awakening to the possibility of acquiring more control over their existence. In this context, the repercussions of a woman acquiring more control over her existence may be far less comfortable for a male partner than vice versa, as the stability of the relationship or family system may be threatened.

In the Canadian Heart Foundation, smoking behaviour among Canadians is a topic area of high importance and is a particular program priority. Various thrusts with respect to women in smoking in the last few years have included a focus on prenatal health and smoking during pregnancy. Much work has been done in conjunction with the Canadian Council on Smoking and Health. Various initiatives have been undertaken between the Canadian Heart Foundation and the Canadian Council on Smoking and Health for over thirteen years. Both the Canadian Cancer Society and Canadian Heart Foundation stress the importance of diet in various programs in order to reduce disease. In this context it is assumed that women may play a particular role as the providers, preparers and organizers of nutritional intake within families. Given that focus, it seems necessary that diet programs need to be oriented, accessible, and meaningful to women. Further, should diet and smoking programs be combined (under a possible idea of the Canadian Cancer Society), they also need to have those characteristics.

At the Canadian Cancer Society women and smoking is seen as a "critical issue" but not necessarily named as a priority. This agency, although eagerly looking forward to direction from the National Program, warns that program implementation depends on a number of factors: the best use of resources and volunteers, the evaluation of a particular program, and the relationship to reduction of mortality from cancer.

Specificity with respect to program development for women and girls is needed; not just at the Canadian Cancer Society but in all disease control agencies. Furthermore, it appears to be wanted. There appear to be no major political or intellectual obstacles to establishing specific directives to guide program development and implementation for girls and women and tobacco use.

C. Women's Cessation Programs

Smokefree

In an interview with Phyllis Jensen, the co-ordinator of Smokefree, a women's feminist-oriented cessation program in Toronto, Ontario, it was stated that women's needs are not currently being met in cessation programs. Smokefree organizers perceive that smoking for women is a fact, a "deep nurturance issue", and that "deep work" in altering attitudes is necessary in order to alter behavioural manifestations of smoking. It is felt that the smoking behaviour symbolizes other sorts of issues for women that need discussion and exchange within all women's groups. Approximately 20 percent of clients, many of whom report other problems including sexual violence victimization, need longer-term therapy.

It was noted by the co-ordinators of Smokefree that women in a change cycle, who are ready to move forward in their lives in other ways, are those ready and able to be successful at smoking cessation. It is often seen as one of a number of acts that a woman might take in order to "take control" of her life. The motivation is often health-oriented but the act of attempting to quit smoking is an effort to take her own health seriously. Many women have perceived the medical system in general as patriarchal and, on occasion, "victim blaming" in its orientation. When it comes to smoking cessation, many women need to feel that they are not being blamed or victimized as a smoker, but rather that they will gain some assistance in taking control of their lives. In the last twenty years of the current phase of the women's liberation movement, the need to be freed of various constraints has been uppermost in many

women's minds and has been a theme utilized and exploited in both health education programs and tobacco advertisements. The co-ordinators of Smokefree feel that mixed groups for cessation programs are acceptable if the women are content with a fairly superficial discussion level in the group. Secondly, it is felt mixed groups are acceptable where behaviour modification therapy is the mode of treatment. Particular methods used in the Smokefree cessation program for women include deconditioning, and a gradual reduction in tar and nicotine intake, increasing the time between cigarettes, and extensive group discussion.

The reported reasons for starting to smoke among those in the Smokefree program include the desire to belong, to be thin, and to control weight. The reasons for continuing to smoke reveal that these women feel 'hooked', or addicted physiologically, and fear that quitting will cause a weight gain. These reasons are not unique, but the experience gained at Smokefree is. The co-ordinators believe that working out the *meaning* of the smoking behaviour is crucial for women. Choosing to assess the deeper meaning of what smoking may mean is seen as a healthy development. The overall message from Smokefree is that women must learn how to be their own 'parent': in other words, women must learn how to look after themselves and take responsibility for their own health through taking responsibility for a set of changes, only one of which may be the alteration of their smoking behaviour.

The success rate of Smokefree is reported as 80 percent at the end of the eight-week program. A follow-up evaluation in currently underway to assess graduates of the last two years.

Manitoba Lung Association

Another women-only cessation program has been run by the Manitoba Lung Association (in Brandon) for the last two years. Two sessions have been completed and one more program is planned for January 1988. Evaluations of these programs have been completed, but the number of participants in each session is very small, so only a narrow range of experiences is being evaluated. These sessions are based on the Kick-It program and, according to Joanne Douglas of the Manitoba Lung Association, the two main themes emphasized are weight control and the building of confidence in the women.

The Association has not decided whether to continue with woman-only cessation programs. One reason for this is that in Brandon, the clients currently requesting cessation programs are largely women, so many women-only groups emerge in the regular cessation program sessions. Further, the new Freedom from Smoking curriculum which will be used beginning, January, 1988, covers the themes of weight control and building of confidence in some detail. Consequently, the co-ordinator feels that paying special attention to actively creating women-only groups may not be as necessary in the future as it has been over the last couple of years.

However, particular benefits from women-only groups are observable in the Manitoba experience. Long-term support groups for purposes of maintenance and relapse prevention were requested more by women than by men. In fact, men infrequently requested long-term assistance. Women in one rural area (Killarney, Manitoba) spearheaded a self-help program which lasted for two months after the end of the regular cessation program. This experience is unique in demonstrating a group taking control of its own program and becoming empowered through that experience. In addition, when discussing maintenance and relapse issues, women talk about different events in their lives. Relapse for women appears to be associated with negative events, such as stresses in their daily existence, conflicts, or difficult interactions. For men, relapse is associated with positive events, such as losing control of maintenance behaviour at a party or other social situation.

The organization and planning for the Manitoba program is worth noting.

1. All leaders and guest speakers associated with the program were female.

2. A buddy system is built into the program.

3. Child care was provided and accessibility for the woman at home was highlighted.

Even so, most participants were working women, and all participants became aware of the program through reading newspaper advertisements (*Health Promotion*: 1986:22).

This program is an example of a woman-only cessation program based on a neutral curriculum, as it has no particular feminist analysis. Compared to the Smoke-free program in Toronto it takes a less analytic approach, as the psychodynamics of women's needs to smoke do not appear to be heavily emphasized. This initiative provides a rare and interesting example of a mainstream health agency adapting its program at relatively little cost, and moving it into rural areas with positive community development results.

With the exception of these two programs, women-only cessation programs do not appear to exist in Canada. Many single-sex groups may occur by serendipity but such unplanned activities do not allow adequate planning or evaluation. Consequently, any experience derived from such informal woman-only cessation programs is not available. Study is underway in the U.K. by Liz Batten on this question. Her research should be monitored in the development of adequate programming and evaluation in woman-only cessation programs in Canada. As important as it is to target prevention programs, education programs and educational aids aimed at women in the faltering stage of smoking behaviour, it is equally important to target women as a special group in cessation program planning.

D. The Women's Movement And Smoking

The woman's movement has, until fairly recently, been largely silent on the issue of smoking. The reasons for this fact are complex, and have been highlighted in Canada (Greaves and Buist: 1986), in the United States (Shear: 1985) and internationally (Jacobson: 1981 and 1986).

Major impediments to progress on this issue include:

1. tobacco company support of women's sport;
2. reliance on tobacco advertisements to support women's magazines;
3. influence of advertising themes stressing emancipation and liberation;
4. a "freedom of personal choice" ethic, basic to early feminist though;
5. a heavy agenda of pressing economic and social issues for women;
6. a heavy agenda of health issues, of health threats specifically and solely related to women, and
7. a lack of information available to the women's movement on the issue.

"In the face of repeated threats to reproductive rights from the 'moral majority'; it is easy to understand why the American women's movement sees smoking as a peripheral issue". (Jacobson: 1986:132).

The women's movement has been blamed for the "silence" on smoking, when in fact the women's movement is largely dependent on volunteer labour and often suffers from acute funding shortages. Consequently, this silence is not an intentional omission, but rather one resulting from choices made between many competing priorities with few resources. Nonetheless, the issue is rising on the feminist agenda in many industrialized countries, including Canada.

The National Action Committee on the Status of Women held a workshop on smoking at the 1986 annual meeting, passed strong resolutions against tobacco advertising and for other workplace regulations at the same time, and in 1987 organized a lobby and presented briefs to encourage the passage of Bills C-51 and C-204. These are political efforts, however, and do not necessarily reflect the nature of the work of the women's health movement, a grass-roots, 15-year-old network in Canada.

DAWN, the DisAbled Women's Network, an advocacy group for disabled women, has appealed to various organizations, including the women's movement, to make all meetings smokefree to increase accessibility for the allergic, asthmatic, and other invisibly disabled women. This initiative is an interesting and potentially fruitful perspective affecting attitudes in the women's movement.

E. The Women's Health Movement

This aspect of the project undertook to locate women's groups in Canada that work in the area of women's health and to gather information with regard to the status of smoking as a women's health issue. The groups were asked to respond to questions regarding the purpose and goals of their organizations, their funding and modes of operation. They were asked about their involvement with smoking and their thoughts as to why women smoke and continue to smoke. Finally, the groups were asked for their thoughts on the need for cessation programs for women, and what issues would need to be included for them to be of value for women who wish to quit.

Thirty-three women's groups in ten provinces were contacted (See Appendices D and E). Telephone interviews were conducted to gain information on the status of these groups and their involvement with smoking as a women's health issue. A snowball technique was used as the method of sampling and selection. Some limitations of this technique should be mentioned. Many of the groups operate on a voluntary basis and without funding so that contact was sometimes difficult. It is possible that groups exist that were not contacted because they are not in contact with, or known by others. The current lack of a formal networking system is one of the factors which limits communication.

The interviews focussed on five main areas:

1. the group's structure, goals and funding;
2. relationship of these groups to mainstream groups and government agencies working on the issue;
3. the level of awareness and thoughts regarding the issue;
4. history of action on women and smoking and plans in this regard, and
5. the groups' perspectives on this issue as a priority.

Of all the groups contacted there was only one women's health clinic which provides direct health services to women on an ongoing, full-time basis. This group is the Winnipeg Women's Health Clinic. This group started fifteen years ago as a group of women who came together to share their health concerns. The group expanded and in 1981 officially became the Health Clinic. The clinic now operates with 20 paid staff, including doctors and nurses, and 40 volunteers. It has an operating budget of approximately $750 000. Manitoba has another full-time project in Thompson called Gate Keepers. This is a three-year pilot project, funded by Health Promotion, whose mandate is to develop and promote women's health in the northern communities. None of the other provinces have women's health organizations providing direct services to women on a full-time basis. The Vancouver Women's Health Collective is another direct service health-specific organization. However, due to limited funding, it is unable to offer its services full-time.

It appears that the women's health movement starts with women who come together to share concerns about health issues *specifically related to women.* The main concentration of these health centres or groups is on reproductive and gynecological concerns. These groups act upon their concerns in many ways: counselling group, individual and peer, workshops, information pamphlets or kits, newsletters, speakers, advocacy and self-help groups. In some areas the groups act as information and resource centres.

All the women reported that their work takes place in areas where gaps in services and knowledge exist. Specifically, the topics covered include D.E.S., menopause, birth control, abortion, pre-menstrual syndrome, Depo Provera and childbirth-related topics. The other health issues addressed focus again on women-specific concerns. These concerns include breast cancer and examination, eating disorders, diet, and nutrition, lesbian health issues, pharmaceutical concerns, and the treatment of women by the health profession. Some of the groups work on health topics that are of general concern but where women's needs differ from those of men. These topics consist of occupational health and safety, mental health, stress, naturopathy, and AIDS issues.

Funding

Lack of funding is a major problem for these groups and severely limits the ability to deliver services and information believed important to the health of women. The vast majority of groups, when they receive money, are

funded by grants on a per project basis. Work is therefore time-limited, topic-specific, and acceptable to the granting bodies. There has been funding made available to groups to produce information kits, conferences or workshops on such topics as stress, PMS, patient rights, birth control, childbirth, nutrition, etc. But groups have also been denied funding on other women's health concerns such as abortion access. Therefore, there is an ebb and flow to some groups depending on funding availability.

One informant mentioned that in order to receive money from The Women's Program, Secretary of State, there was a need to convince the funders that an issue was woman-related. The example given was a group which had applied for money for a workshop on environmental health. This criterion could greatly affect the ability of women's groups to apply for funding on smoking. Because smoking has not been typically viewed as a women's issue, money may not be readily available from some sources.

Almost all the groups contacted are dependent on the use of volunteers. Some receive no funding and only exist because of the volunteers' commitment. The lack of core funding places restrictions on the groups' abilities to provide consistent services to meet the needs of the female populations they serve, as well as on the ability to be visionary with respect to issues such as smoking.

Relationship To Mainstream Health Organizations

The women's health movement grew and continues to grow out of a recognition by women that mainstream health organizations often fail to recognize and act upon the specific needs and concerns of women. All groups reported that they work in areas where gaps in services or knowledge exist. One of the more obvious examples has been the involvement of the Winnipeg Women's Health Clinic and the Vancouver Women's Health Collective, with women receiving compensation for injuries they received as a result of using the Dalkon Shield IUD. Information on D.E.S, PMS, and Depo Provera, for example, has been made widely available through the efforts of these groups.

The groups contacted do work with existing agencies where possible. Often, however, there are no other organizations that are able to assist, or assist in a way that recognizes the needs of women. The role of some groups often is to work to change the attitudes and services of the mainstream health community. In Nova Scotia, the role of W.H.A.M., (Women Health And Medicine), for example, is to educate and increase the awareness of the medical profession on issues related to the treatment of women medical students and women patients. Other examples are groups that provide information and assistance in the area of reproductive technology. Mainstream organizations exist which disseminate information about birth control, but they do not provide all necessary resources and information, nor, it is felt, do they provide it in a way that is necessarily in the best interests of women.

Women's groups are willing to work with other organizations and will use the resources that are available to them from such groups when their issues coincide. However, women are often forced to meet their own needs by developing their own resources and programs. Where the women's group has developed a need that is not recognized by the main-stream health community, there may be no positive relationship at all with the mainstream agencies.

Ideas About Women's Smoking Behaviour

A number of impressions and ideas were put forward by the respondents as to the reasons why women begin to smoke. Many women said the social context of their lives was a factor. Smoking was considered socially acceptable. It was a visible way of demonstrating maturity and has been looked upon as a demonstration of "liberation". Peer pressure was also seen as an influencing force. Some suggested that women start to smoke when they are bored, or because they want something to do, particularly with their hands. Sometimes smoking is believed to give a sense of security, or is a means of relieving stress. The stress in women's lives is increasing as more women become single parents and/or are required to work two jobs – one inside the home and one outside the home. Women were also said to commence smoking as a way to maintain or lose weight.

The issue of increased smoking among adolescents was of great concern. Peer pressure, the idea that smoking is seen as an act of rebellion, and the belief that smoking is a sign of maturity are particularly significant to these women, it was felt. One interviewee indicated that these were more significant

reasons for females because, as teenagers, girls generally experience more repression than boys of the same age. It was also mentioned that young people do not believe that smoking will have an effect on them. The *Canadian Youth and Physical Activity* report gave evidence that slightly fewer girls (59 percent) regarded not smoking as being very important than did boys (62 percent). But 60 percent of female youth saw weight control as very important, compared to 39 percent of males.

> "The question raised by this pattern of results is whether female youth are attempting to control their weight by smoking instead of by exercise or perhaps in addition to exercise. Since tobacco is an appetite suppressant, it may be successful enough as an ally in the adolescent battle against excess weight to become firmly established as a life-long habit."
>
> (Canada Fitness Survey, *Canadian Youth and Physical Activity*, Fitness and Amateur Sport, October 1983, p. 22)

The New Brunswick Advisory Council on the Status of Women, in a report entitled *Health of Adolescent Girls: Principles and Recommendations* (December, 1985), utilized this information in making the connection between girls' smoking and their desire to lose weight. The N.B.A.C.S.W. report also expressed concern for the increased risk of cardiovascular problems for women who smoke and take oral contraceptives, a particular concern with respect to young women.

Many women felt that advertising was an influence in starting to smoke. One respondent felt many of the ads imply that smoking equals fun and leads to happiness. If you smoke you will have men, friends, be healthy, active and achieve status. We are all familiar with the ad "You've come a long way, baby." The smoking ads were seen as being particularly influential on younger women. This phenomenon, coupled with young people's attitude that smoking will have no ill effect on them, was of particular concern to a number of the women interviewed.

Maintaining Smoking Behaviour

Although many informants identified the addictive aspect of smoking, few made the connection with other drug and alcohol dependencies. The women's groups that had worked on chemical dependencies had not included tobacco, and only recognized this link after it was proposed. Strong support for including smoking quickly emerged.

There was concern and awareness about the relationship between smoking and weight. One respondent suggested that it was perceived to be more important for women to look healthy, because they are valued for how they look, than to actually *be* healthy.

Socioeconomic Status

Smoking was of greatest concern to those groups working with low-income women. The Support for Single Mothers group in Moncton, reported that 90 percent of the mothers using their services were smokers. Those who have worked with low-income women have had little success in working on health-related issues. The Support for Single Mothers group attempted to run a workshop on smoking cessation, but no one attended. The North End Women's Centre, in Winnipeg, reported similar problems when trying to promote smoking cessation with their client population. One woman believed that there were fewer successes with the low-income groups, as compared to middle-income women, because of the amount of control that women feel they have over their lives. The self-help approach was seen as more successful with middle-income women because these women generally have a greater sense of control over their lives. Lower income women feel they have little control over what happens to them. In the groups that worked specifically with low-income women, there was no "non-smoking" policies in place, as it was felt that for many women on social assistance, smoking was the only pleasure they had. Native women, it seems, are particularly sensitive to being pushed about their smoking habit. Smoking is seen to be a part of the native cult[illegible]. "Alcohol is the white man's way, tobacco is the native's." There is, therefore, strong resistance to having it taken away. This perception presents a special and serious challenge to smoking and health educators.

Stress

Many women made the connection between stress and smoking when discussing why women continue to smoke. Those women who expressed a holistic approach to health viewed smoking as a symptom of stress. Inadequate incomes, child care, safety, and housing were identified as some of the major concerns

which lead to stress. Those involved with women in crisis, such as battered women's shelters, often felt that to discuss smoking would only add to the stress the women were already experiencing and it was not a concern to be addressed at the time. One respondent said that some of the clients she works with say they will quit smoking after they made other more immediate changes to their lifestyle. The women who supported this outlook said that to consider only the smoking would be to ignore the causes and stresses that women face and could be used to reinforce the "victim blaming" that women must work against.

History of Action on Smoking

The vast majority of women in the women's health movement have not identified smoking as an issue to be embraced. Of all the groups contracted, few have ever provided smoking-related programming. Two of the groups had provided one-day workshops and two had attempted to implement a cessation program. Two of these groups work directly with low-income women. The results were unsuccessful, due to lack of attendance. In Saskatchewan, workshops have been presented and have been well-received, particularly by rural women. The only cessation program (as opposed to workshop) that was successful has been produced and implemented by Gate Keepers, in northern Manitoba, on a three-year federal grant. They have completed a six-week "women and smoking cessation group" and they are preparing another one which is to be four weeks in duration. The focus was on cessation techniques and nutrition concerns. The workshops were designed with the assistance of the Cancer Society and the Lung Association. Regina Health Sharing has also provided one-day workshops on women and smoking which were well received.

Smoking as a Priority Issue

Smoking was not seen as a priority issue by almost all the organizations contacted. Although many said smoking has been raised, the decisions as to priorities are often taken by the group as a whole, and there has never been a consensus to work on smoking. Some groups only provide information according to requests received. In some groups the members were non-smokers and smoking was therefore not a concern to them. In other groups, smoking was seen as a personal issue, and therefore not a group concern. For some groups the solution has been to have non-smoking offices and meetings, with breaks for those who smoke. It appears that this activity is then seen as a "solution" to the problem. With more and more buildings and offices becoming non-smoking spaces, the "problem" of smoking is seen to disappear. This perception leads to a position of "out of sight, out of mind", which can further bury this issue in the women's groups' agendas.

There appear to be significant regional and class differences in the concerns around smoking. It is of a much greater concern to those who work with low income women than it is to those who are involved with middle-income women. There is a much greater concern about smoking by women in Eastern Canada than there is by women in Western Canada. The groups operating in Quebec, for the most part, do not have "no smoking" policies, unlike the groups in most other areas. The rural women in the Prairie provinces express a concern about smoking, but the Women Today group in rural Ontario does not report smoking as a major issue. One possible reason is the differential access to information through other organizations. It is seen as less important for the women's groups to provide the information, if other groups can provide such assistance.

In 1984, the Northern Ontario Women's Health Education Project sponsored a project called *A Survey of Women's Health Needs in Northwestern Ontario.** A needs assessment questionnaire was developed to assess a broad range of women's health needs in the regions of Thunder Bay and Kenora. In terms of quit smoking classes, 13 percent of the 478 respondents thought they were available, 51 percent said they were needed, 15 percent said they were not needed and 22 percent did not know. Of the 13 targeted communities the range of perceived need varied from 25 to 86 percent. One of the recommendations of this project was as follows:

> "The requests for a workshop to help women quit smoking were frequently made. The Ministry of Health and Public Health Department needs a rigorous education program on the hazards of smoking. But, if as suggested

* Northwestern Ontario Womens Health Project: 1984:54

by the data, women smoke to calm their nerves, then women need an alternative means such as improved coping skills, reduced stress and increased fitness."

Smoking As A Women's Issue

Approximately 85 percent of the women's groups surveyed felt there should be separate programming for women and cessation. There were many issues identified as being different for women, such as the stressors that lead to smoking. More than one woman reported that the information women share with each other is different when it is in an all-female environment. The most often repeated perceived difference was the relationship of smoking and weight gain. One health worker stated that because women are valued for how they look, they consider it more important to be thin than to be healthy. Another indicated a need to distinguish between the adolescent smoker and the one who has been smoking for 20 years.

Women in our society are often those who do things for other people. This fact appears to be true in the concern about smoking. There is a great deal of information with regard to the dangers to the fetus of women who smoke while pregnant. Smoking in this context is addressed by those groups that work in the area of pre-natal care. A number of women remarked that they knew of women who had quit smoking while pregnant and had started again after the birth of their child. One woman commented that cessation programs should consider the entire family. She expressed concern around the difficulties that can exist when only one member of the family quits while the other(s) continue to smoke.

All groups contacted were limited in their activities by funding constraints. They felt their main role in the community was to provide information and services where none existed. If a service was already being provided, they wouldn't duplicate it, but rather provided services or information that other groups wouldn't provide. As larger centres offer smoking cessation programs through mainstream organizations such as the Lung Association, this type of programming was not seen as a need to be filled by women's groups.

Consequently, the women's health movement in Canada is not actively involved in the smoking issue. Smoking is only starting to be perceived as a women's issue. While women tend to acknowledge that many of the concerns around smoking relate to women differently than men and that there should be smoking cessation groups for women only, there has been a gap in linking smoking to the feminist perspective.

It appears as if a major block for women's groups becoming more involved is that there are many health issues that solely concern women and are not being considered by other groups, and are therefore a major concern for women's health groups.

Quebec

Ten sources were contacted to gain an understanding of the women and smoking issues in Quebec, (see Appendix E). Five were women's groups or contacts, and five were mainstream disease control agencies.

As one of the mainstream organizations, the Quebec Cancer Society is involved in fund-raising only and has no public programs. The Seventh Day Adventists promote a community program called the "5 Day Plan" to stop smoking. It is offered to both men and women and does not differentiate between the sexes. The contact, E. Morosoli, believes there is only a slight difference between men and women and says they accommodate this difference in their program. The Heart Foundation has no special project for women, however after hearing the talks at the 1987 Canadian Council on Smoking and Health workshop recently, now feels it needs to look at women and smoking in a special manner. In April 1987, the Quebec Non-Smokers Association undertook a study on smoking and young women. The target population was secondary schools, colleges and some elementary schools. It was anticipated that the results will equip them with information to decide on how to target women to stop smoking.

Five contacts were made within the area of women and health:

1) The Centre des Femmes de Verdun uses general bulletins on smoking and its effect, but no work is being done specifically regarding smoking and women. The organization is presently discussing reduction of smoking in the centre. Half the staff are smokers.

2) The Centre de Santée de Femmes in Montreal concentrates on women and drug use. Women are allowed to smoke in the centre and half the staff are smokers. There are no plans to study smoking as it pertains to women and it has not been thought about as an issue. It was felt that professionals (i.e. doctors) tell women about the effects of tobacco and that the problems of smoking are the same for both women and men. This group has no relationship with other organizations which deal with the issue of smoking.

3) The Hôpital Citeé de la Fountée Laval completed a project on smoking and women in the hospital two years ago. It consisted of a book-mark and a message on health for women. This hospital has non-smoking areas and is presently planning research to determine whether it should become totally non-smoking. It is also contemplating use of the radio as a means of disseminating information.

4) The Quebec Family Planning group has been involved with women and health. They are concerned about pregnant smokers but they have not acted upon or thought about other issues in relationship to women and tobacco. The office has no official smoking policy.

5) Hugette Dagenais, who works at Laval University, researched and published a working paper on women and tobacco, but has no further interest in this area.

It appears as if the situation in Quebec is similar to other areas of the country, in that women and tobacco are not being addressed. In some ways it lags behind other provinces' women's groups that have established non-smoking policies within their centres. The lack of action could also be related to the high number of women who smoke within the organizations contacted. In other areas where non-smoking policies existed, the majority of the workers were non-smokers. In the issue of smoking there seems to be a connection between the personal state of those who work within the organization and their response to the issue of smoking.

F. Issues For Future Action

28. An outreach program needs to be conducted by local, regional and national sections of the major disease control organizations, advocacy organizations and government departments, to their parallel status of women organizations, women's institutes, branches of the National Council of Women, and advisory councils, to ask for and promote involvement in action against smoking in women. In addition, those smoking control agencies offering programming for women should invite input or co-sponsorship from women's health groups at local, provincial, and national levels.

29. The Secretary of State Women's Program, and Health and Welfare Canada need to encourage women's health groups to develop proposals for funding for women's programming in smoking including the development, testing and evaluation of a women-centred cessation program curriculum, based on consultation with women's groups and based, in part, on qualitative data from women.

30. The women's health movement needs access to operational funding, so that attention can be paid to the women's aspect of general behaviours (such as smoking and drinking), in addition to women's specific health issues (such as PMS, DES, or childbirth), and so that women's groups could assist in developing models in conjunction with mainstream groups.

31. Efforts need to be made to organize a review of ALL smoking education materials currently in use by government, disease control and advocacy organizations, assessing for sex bias or the unequal, inaccurate or superficial treatment of the women and smoking issue.

32. Associations, unions or organizations of female-dominated occupations (nurses, teachers, secretaries, social workers, occupational therapists, physiotherapists, etc.) and women's sections of other occupational groups, need to be encouraged

to publish materials on smoking and women, and co-sponsor worksite cessation programming.

33. The organization representing female physicians needs to be encouraged to play a leadership role in organizing action against women's use of tobacco.

34. Collaborative efforts using various media need to be made to educate and influence women on the subject of tobacco use, such as:

    i) the development of video/audio tapes (to provide access to information to the rural dweller, the less literate, the physically disabled and the visually impaired;

    ii) the development of a film on women and tobacco use (possibly by Studio D, National Film Board), and

    iii) the production of a pamphlet on smoking as a women's issue.

Chapter 9

A. Some Future Programming Directions

In future, programming new and creative ideas will be necessary, both to offer the desired support and direction to the health education authorities and community groups and to make meaningful change in the smoking behaviour of women and girls. The general health messages regarding smoking are not having the desired effect on certain subsections of the smoking population, teenage women, young adult women and groups such as native women, older women or economically disadvantaged women. In order to affect these more resistant subgroups, it is necessary to develop new approaches, re-focus current policy and program development in prevention, public education and cessation, and to strategically market materials to these groups.

"Health Plus" Messages

Although the health message is vital and remains the basis for concern with altering smoking behaviour among girls and women, it is important to stress other themes in prevention, education and cessation materials. The 1988 Non-Smoking Week theme of women "taking control" of their lives through "choosing not to smoke" is an example of a psychological and political message. This perspective needs further development and similar social, psychological and political messages need to be transmitted to various subgroups.

Language

A second basic change is necessary with respect to language. The language that is currently used in all areas is often quite negative. For example, cessation implies loss, death, and ending. Phrases used in cessation include "stopping smoking", or "smoking stinks", and "anti-smoking". In prevention, the language is "never smoke", and in public education some of the language is even more dramatic; "losers smoke" or "smoking kills!". Some of this language may have reduced or altered smoking behaviour in certain kinds of smokers, but serious consideration to making the language positive may have similar desirable effects on some resistant groups. Although an awkward phrase, "starting not to smoke" may well be more appealing than "stopping smoking". Staying "smokefree" is a positive phrase. "Taking control" is also a positive phrase, as is "freedom from smoking". There must be a decided effort to generate positive phrases and words that can be used in the campaign against smoking.

Prevention

The attempt to prevent girls and women from taking up smoking is difficult, but the literature in Chapter 3(B) allows the identification of a few themes pertinent to prevention.

1. The attempt, desire or need to belong to a group influences the initiation of smoking behaviour in girls.

2. Girls are initiating their smoking behaviour between the ages of 12 and 15.

3. Teenage girls, like adult women, appear to use cigarette smoking as an appetite control mechanism and may have dieted in pursuit of the ideal body.

Since teenage girls are also the most unfit group in the population, it seems that a productive health education campaign aimed at prevention would best be holistic, dealing with fitness, diet, weight and appetite control, as well as smoking. If the concerns about weight gain and body image are addressed properly there could be an improvement in the smoking behaviour in this age group. Such a prevention direction needs considerable study. The design of a specific, well-tailored program, to test longitudinally, would be necessary.

The self-image issues specific to girls (and later women) are considerable, and stem from deep-rooted socialization practices. Although not apparently within the limits of a smoking prevention campaign, issues such as negative body and self-images among girls are of importance and must be incorporated into a productive, holistic prevention program. Attention must be paid to the shifting in girls of the locus of control for external to internal. The widening of the cultural acceptability of different body shapes and sizes, other than those promoted in fashion and media, and the

generation of social approval for women's physical fitness, strength, and involvement in competitive sport are serious systemic modifications that need to be made in our culture in order to create and support a pro-health attitude among young women. Equal funding of team sports for girls would contribute considerably to redefining women's health.

The relative inactivity, poor physical health and poor health habits (such as smoking) in girls and women reflect aspects of the society in which we live. As teenage girls become more aware of the limits on their futures and cultural pressures on their behaviour, they experience a feeling of less control over their lives. It is in this context that the immediate gratifications of smoking – social, psychological and physiological, take on a powerful attraction.

Public Education

Public education puts messages into the public domain and will therefore be general, but there are specific communities to be targeted, using public education techniques and specific themes to be expressed in such material. A geographically-based community could be a focus, to point out regional differences in smoking behaviour. This approach might well be used to target Quebec women, for example, to inform them about their higher than average smoking rate. Communities of people who have something in common can be targeted, such as the women's community or the native women's community. These communities span all of Canada and are linked together through common interests and goals and a basis for interaction. These community structures can be utilized to disseminate additional messages, or to incorporate messages regarding smoking behaviour in women into those currently being disseminated.

A general recommendation is to recognize both geographical and non-geographical communities and to utilize their existing structures for the purposes of spreading smoking education messages. Carrying out this recommendation well means that the development of a communication network among the various communities and between these communities and government, health or disease control agencies will be necessary. Such lines of communication do not currently exist. A second consequence of developing these communication networks would be an increased mutual understanding between these communities. This activity would be very beneficial as it would reduce suspicion, distance and alienation. Eventually the development of local co-ordinating committees, including representatives from the various sections of the communities, could plan or evaluate public education co-operatively in local areas.

Non-Smokers vs. Smokers

Another target for public education messages are the non-smokers and ex-smokers in the population. In recent years, these groups have become the majority in Canada. This fact has allowed both the development of increasingly restrictive smoking legislation and the development of new norms regarding smoker non-smoker relations. As positive as these developments are for decreasing smoking prevalence, there are latent or unintended consequences to these new norms.

Smokers experience new social configurations in new "smoking lounges" (or on porches at parties), based solely on smoking status. Similarly, non-smokers group together, based on their non-smoking status. This grouping behaviour sets up a we/they conceptualization and increases the distance between the groups, as the non-smokers gain confidence and the smokers "dig in".

The behavioural implications for smokers include the solidification of the identify of "smoker", the increasing attachment to the support of the other smokers, and the reluctance to abandon smoking friends by quitting.

From the non-smoker's point of view, there is an increasing vigilance directed at the behaviour of the smoker, and sometimes an increase in hostility. This hostility is unfair as it targets the smoker herself as the scapegoat for the tobacco industry and exploitation by tobacco advertisers. It also ignores the fact that tobacco is an addictive product and that people caught in its net are in some ways trapped. It is necessary to avoid regarding smokers as victims, however, as it implies that control may be hard to acquire. A subtle public education message to the non-smoker is necessary to generate co-operation between non-smokers and smokers, and to find support for the smoker, without preaching, re-victimizing, isolating, alienating and driving away from potential sources of support. If these attitudes were available in the non-smoking majority in a more sympathetic form, the smoker may, despite her new social support mechanisms created by increasingly restrictive rules, be more inclined to give up the habit

and enter into the non-smoking majority, knowing that she will be welcome and expected.

A specific theme to be generated is a "take a smoker to lunch" approach. Identify with a smoker, co-counsel a smoker, adopt a smoker, are all variations on this theme which could be incorporated into public education messages and perhaps into community pilot programs.

A second theme to be developed with non-smokers is to understand smoking behaviour as one of a series of addicted behaviours. In general, there is much more sympathy for the addicted drinker, or drug user, than for the smoker. We ascribe less responsibility to other kinds of addicts than we do to smokers.

Another specific theme for public education programming to the general public is the promotion of the acceptability, and perhaps the necessity for smokers to make repeated efforts to quit smoking. (There is a direct analogue in the battered women's movement. Ten years ago public and professional groups alike refused to support battered women who repeatedly returned to violent homes. Sometimes many cycles of violence occurred as the woman increased her ability to cope. Education programs dealt with this attitude directly with some success.) Similarly, as people try to quit smoking, many attempts are needed. These attempts all represent progress because in each one the smoker has quit for a while, smoked fewer cigarettes, made some effort, experienced non-smoking and deserves commendation.

Community Programs

A general recommendation is to incorporate these ideas regarding different types of communities, and the specific themes, into two pilot community programs. Two communities in Canada can be designated, one rural, and one urban, paying particular attention to francophone and anglophone elements for the development of multifaceted community education programs. These programs would include the strong public education component as well as prevention and cessation programming allowing for longitudinal evaluation. These programs should be twin projects, well-funded for at least a three-year period. The project of developing a woman-only cessation program could be incorporated into these community programs. These two pilot programs should be directed specifically at girls and women but the public education component of them needs to be somewhat more general.

As a general principle, the entire community needs to be involved in the battle against women's smoking. Awareness would need to be raised, and the co-operation of employers, health education authorities, the women's health movement and other women's groups would be required, following a community development model. An element of competition between the two communities could be considered, not necessarily to the program's detriment. Non-smokers and smokers need to be encouraged to work together in very specific ways to defuse the hostility between the two groups that appears to becoming increasingly evident in the Canadian population.

Cessation

In the area of cessation programming for girls and women, specific targeting of subgroups is necessary in order to be more effective. As it appears unreasonable to assume that the same messages, teaching techniques and modes of communication will be as effective with girls and women as with boys and men, sex segregated programs need to be established. In the short term, it seems relatively cost-efficient to simply modify existing group cessation programs by reorganizing the class groupings. In the meantime, a project needs to be undertaken to develop a specific cessation program curriculum for women, incorporating available research in the area of women's cessation as well as qualitative, experiential data from women smokers. In the long term, through the establishment of such a pilot project, a tailored woman-only, woman-centred cessation program could be developed for application through disease control agencies or through independent women's groups. Further, a self-help guide and curriculum could be developed to serve self-quitters.

Kit on Women and Tobacco

If a kit about smoking along the line of the "It's Just Your Nerves" addiction kit is produced, a training program for facilitators would ensure that it were used in a relatively standardized way at the community level. Women's groups, women's health agencies, mainstream health education agencies, high schools, universities, colleges and social service agencies could use the kit to transmit the principles of smoking education for women. This method has the obvious benefit of

developing, through public participation, the available community resources in Canada.

Workplace Cessation Groups

Sex-specific workplace programs could target particular occupational groups, such as secretaries or nurses. This way, issues specific to the workplace can be incorporated into the discussions surrounding the "taking control" of smoking behaviour. Problems of particular work groups, (such as nurses' positions in the medical hierarchy and their amount of job stress), could be discussed and contribute to a collective "taking control", that can transcend into the personal sphere. The sharing of common occupational experiences which may be contributing to their smoking behaviour may empower the participants.

Well-Targeted Poster Campaigns

The next idea is a well-targeted publicity campaign, in the form of posters and/or pamphlets directed at specific populations with a "starting not to smoke" message and a woman's non-smoking logo. A general format and theme, with the insertion of various scripts for specific populations could be developed. In this campaign, the use of a well-recognized female role model for each of the sub-populations to offer the non-smoking message is necessary.

1. Nurses: a well-known nurse pictured on a poster making a statement such as "Our profession has undergone major changes in recent years. We have had to take control of our work situation. It's now time to take control of our personal health." Added to this statement would be a "starting not to smoke" message, the woman's non-smoking logo, and information on further action for individuals.

2. Disadvantaged women: (battered women, women in therapeutic groups, women in women's centres, women in sole support mothers groups, women on welfare). The message would be this. "Many things are changing in your life right now. Some have to change, some you can choose to change."

3. Teenage girls: a teenage role model could be pictured on the poster saying something like "I can eat whatever I want if I'm active and fit."

4. Native women: a figure from the native women's community, saying something like "Our people need our heath, our energy, our money. Tobacco use isn't helping any more."

5. Women's movement in general: to target young adult women who are politically active a statement such as "Women's liberation is both political and personal: it's changing the system and it's changing us. Let's liberate ourselves from smoking."

6. Alcohol abusers: in this case the message is to try and shift out of the double dependency: making a "clean break". Many other examples could be generated.

Conclusion

All three of these future directions in cessation could be incorporated into the community demonstration project on women's smoking. In conclusion, future themes for the consideration of government and health education agencies are:

1. Specifying as an explicit goal the integration of the various communities in the country that could be linked together co-operatively, to make changes in the smoking behaviour of girls and women. This blending of expertise needs to be done in a non-defensive atmosphere with openness on all sides. Currently, there appear to be few obstacles to this process.

2. A second theme is that governments and health education authorities must accept that a sex-segregated approach may possibly be the only option in reducing smoking behaviour in some girls and women.

3. The language used in smoking programming needs considerable revision to make it more positive.

4. Although the health education message is vital to programming, other themes (psychological, political and social) need to be emphasized.

5. The productive involvement of the non-smoker and ex-smoker in the problem of women's smoking is long overdue.

The issue of women's tobacco use in Canada is pressing. Much work needs to be done to lower the rates of smoking initiation in young women and to increase rates of cessation in adult women. Continuing study and analysis of women's smoking behaviour is warranted. It is understood that women's smoking behaviour is different from men's, and yet it is not completely clear as to what extent the research in this area must become not only more finely focussed, but also more wide-ranging.

As awareness is raised about sex differences in smoking patterns, it will presumably be less and less frequent an occurrence to see research, education, or evaluation done without incorporating an awareness of gender. Any interested agency, government body or researcher reading this report should realize that research and evaluation can only be improved by incorporating an awareness of both sexes into the work. Every program, leaflet, poster, research question or advertisement needs to be considered or reconsidered with this perspective in mind. A valuable guide to this process is *On The Treatment Of The Sexes In Research*, (Eichler and Lapointe: 1985).

Much can be done quickly and cheaply to improve the situation for women smokers in Canada. In the short term, a simple reorientation or refocussing may result in some immediate yet powerful changes. Changing the face on an advertisement or the text in a leaflet or the gender of a doctor giving advice, are but a few meaningful short-term changes that could affect smoking behaviour in women.

In the long term, more profound changes need to be made in the response systems to women in Canada who smoke and to those girls who are vulnerable to making the wrong choice in smoking. These longer-term changes must be based on considered, strong research programs, or pilot studies on a community level that result from the collaboration of all pertinent agents in the community and are well evaluated. Some initiatives in this regard are clearly needed if Canada is to continue its commitment to fighting the problem of women's smoking. These initiatives should be community-based, integrate all available resources in the community with respect to both women and tobacco use, should automatically incorporate a gender analysis, and should not ignore the power of involving non-smokers and ex-smokers in such efforts.

Thirteen thousand women die in Canada per year of smoking-related diseases. A woman in Canada dies every 40 minutes as a result of her smoking habit. In addition, many women experience ill health and incapacity due to smoking-related illnesses. These facts represent serious losses of the valuable resources of women's health and lives. The history of the problem of women and smoking is relatively short as women's issues go. Only for approximately 60 years has women's smoking been a widespread practice in Canada. Although the more dire health indicators of this smoking epidemic, (such as lung cancer rates), have yet to peak, we may be assured that in the context of women's issues, this one has had a relatively short history and increasingly, a limited future.

There is no doubt that the three major health challenges facing Canada today, "Reducing Inequities"; "Increasing the Prevention Effort" and "Enhancing People's Capacity to Cope" (Epp: 1986), are central to the issue of women and smoking. General and persistent inequities in Canadian society have produced a situation where women's ability to cope is depressingly low in many cases, and perceived to be 'enhanced' by dependence on tobacco and other substances. Although prevention efforts remain high on the agenda in the attack on women and smoking, such efforts will be fruitless until basic changes in the social and economic structure in Canada produce an improved, 'enhanced' life experience for women.

B. Issues For Future Action

35. Consideration needs to be given to developing more non-health messages as themes in prevention campaigns, utilizing positive language to describe desired behaviours.

36. Public education efforts need to target non- and ex-smokers to develop co-operation in the fight to reduce women's (and men's) smoking, and to

defuse the current social hostility and alienation felt by many remaining smokers.

37. A comprehensive, flexible poster campaign on cessation needs to be developed, using the women's non-smoking logo, and recognizable figures to appeal to various subgroups of women and to various regional groups.

38. Two communities need to be designated to develop, test and evaluate multi-faceted campaigns to reduce women's smoking.

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Appendix A

Statistical Tables A–L

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Table A

PERCENT DISTRIBUTION OF THE POPULATION 15 YEARS OF AGE AND OVER BY SEX, AGE GROUP AND SMOKING BEHAVIOUR, CANADA, 1986

		SMOKING BEHAVIOUR					
			NON-SMOKERS			SMOKERS	
		Total %	Never Smoked %	Former Smokers %	Regular Cigarette Smokers %	Occasional Cigarettes Smokers %	Pure Pipe And/or Cigar Smokers %
BOTH SEXES							
TOTAL	15 Years +	19 694 185	44.4	22.9	28.2	3.0	1.5
	15–19	1 873 461	70.8	7.8	17.6	3.5	–
	20–24	2 238 867	49.6	13.5	31.7	4.6	–
	25–44	8 172 866	39.1	22.7	33.4	3.2	1.6
	45–64	4 860 648	38.1	28.2	29.4	2.4	1.9
	65 Years +	2 548 344	49.3	32.4	14.4	1.5	2.4
	20 Years +	17 820 724	41.6	24.5	29.4	2.9	1.7
MALES							
TOTAL	15 Years +	9 623 890	35.9	27.3	30.8	3.1	2.9
	15–19	957 977	70.8	7.9	17.4	3.8	–
	20–24	1 129 658	50.3	12.8	31.3	4.4	1.1
	25–44	4 054 787	33.7	24.4	35.4	3.5	3.0
	45–64	2 385 709	24.2	36.5	33.6	2.2	3.5
	65 Years +	1 095 759	24.4	50.0	18.6	1.8	5.2
	20 Years +	8 665 913	32.1	29.4	32.3	3.0	3.2
FEMALES							
TOTAL	15 Years +	10 070 295	52.5	18.6	25.8	2..9	0.2
	15–19	915 484	70.8	7.8	17.8	3.3	0.3
	20–24	1 109 209	48.9	14.2	32.0	4.8	–
	25–44	4 118 078	44.4	21.1	31.4	2.9	–
	45–64	2 474 939	51.4	20.3	25.3	2.6	0.4
	65 Years +	1 452 585	68.0	19.1	11.3	1.3	–
	20 Years +	9 154 811	50.6	19.7	26.6	2.8	–

– Data not available

Table B

PREVALENCE OF REGULAR CIGARETTE SMOKING IN THE POPULATION 15 YEARS OF AGE AND OVER BY SEX, AGE GROUP AND PROVINCE, CANADA, 1986

		CANADA	PROVINCE								
		TOTAL %	NFLD. %	P.E.I. %	N.S. %	N.B. %	QUE. %	ONT. %	MAN. %	SASK. %	ALB. %	B.C. %
BOTH SEXES												
TOTAL	15 Years +	28.2	31.1	25.4	30.6	30.6	33.6	25.8	27.7	27.3	29.1	21.9
	15-19	17.6	19.2	8.6	18.9	20.6	21.9	15.5	13.4	16.0	19.4	13.8
	20-24	31.3	34.5	27.8	37.7	34.7	37.4	27.9	25.2	32.5	31.1	29.7
	25-44	33.4	37.8	32.5	38.2	36.6	38.6	31.0	34.7	34.6	32.6	25.3
	45-64	29.4	30.4	29.3	31.0	30.3	34.8	27.0	30.8	28.2	31.3	22.3
	65 Years +	14.4	18.3	11.9	12.2	18.0	18.4	12.7	15.8	11.5	15.9	11.4
	20 Years +	29.4	33.0	27.4	32.0	31.9	34.8	26.8	29.2	28.6	30.2	22.7
MALE												
TOTAL	15 Years +	30.8	35.3	31.1	32.7	33.6	36.8	28.0	29.9	29.2	31.7	24.0
	15-19	17.4	24.1	14.2	19.7	20.2	20.1	16.7	10.7	12.8	19.3	12.3
	20-24	31.3	38.3	33.6	37.0	33.4	37.2	27.8	26.1	34.8	29.3	26.9
	25-44	35.4	40.3	34.8	37.6	38.4	39.6	33.9	35.9	36.2	35.6	27.5
	45-64	33.6	37.1	39.7	36.0	35.3	41.8	29.1	35.6	30.1	35.7	26.7
	65 Years +	18.6	23.4	18.6	18.7	27.1	27.2	14.2	20.4	15.8	18.6	14.1
	20 Years +	32.3	37.1	33.3	34.3	35.3	38.5	29.2	32.1	31.0	33.1	25.2
FEMALE												
TOTAL	15 Years +	25.8	26.9	19.8	28.7	27.8	30.6	23.7	25.5	25.5	26.6	19.9
	15-19	17.8	14.2	2.7	18.0	20.9	23.7	14.3	16.1	19.3	19.5	15.4
	20-24	32.0	30.6	21.8	38.3	36.1	37.6	27.9	24.4	30.0	33.0	32.5
	25-44	31.4	35.3	30.1	38.8	34.8	37.5	28.3	33.6	33.1	29.4	23.1
	45-64	25.3	23.5	19.2	26.3	25.5	28.2	25.0	26.3	26.3	26.9	18.0
	65 Years +	11.3	13.8	6.8	7.2	10.8	12.1	11.5	12.3	7.9	13.8	9.4
	20 Years +	26.6	28.9	21.8	29.8	28.6	31.2	24.6	26.5	26.1	29.4	20.3

Table C

PREVALENCE OF REGULAR CIGARETTE SMOKING IN THE POPULATION 15 YEARS OF AGE AND OVER BY SEX, AGE GROUP AND EDUCATION, CANADA, 1986

		EDUCATION					
		Total %	0 to 8 Years %	Some Secondary And no Post-Secondary %	Some Post-Secondary %	Post-Secondary Certificate or Diploma %	University Degree %
BOTH SEXES							
TOTAL	15 Years +	28.2	31.3	31.6	24.9	24.5	14.5
	15-19	17.6	25.3	17.4	13.5	8.6	–
	20-24	31.7	48.0	41.2	21.3	23.1	6.5
	25-44	33.4	45.2	39.5	32.5	26.9	15.3
	45-64	29.4	34.8	30.0	20.7	27.2	16.8
	65 Years +	14.4	17.5	14.0	7.7	7.2	6.1
	20 Years +	29.4	31.6	34.2	26.0	24.7	14.5
MALE							
TOTAL	15 Years +	30.8	38.5	33.0	24.4	28.3	17.6
	15-19	17.4	28.9	17.0	8.9	9.5	–
	20-24	31.3	60.0	40.6	17.0	21.8	8.2
	25-44	35.4	49.6	40.8	34.1	30.5	19.3
	45-64	33.6	42.1	33.2	23.9	32.7	18.8
	65 Years +	18.6	25.3	14.4	2.6	14.5	4.7
	20 Years +	32.3	39.0	36.2	25.9	29.5	17.6
FEMALE							
TOTAL	15 Years +	25.8	24.4	30.3	25.3	21.3	10.4
	15-19	17.8	21.2	17.7	17.4	8.0	–
	20-24	32.0	34.8	41.8	26.0	24.2	5.2
	25-44	31.4	40.9	38.3	31.1	23.7	10.4
	45-64	25.3	27.2	27.4	17.5	22.5	13.4
	65 Years +	11.3	10.7	13.8	10.7	3.7	2.8
	20 Years +	26.6	24.5	32.4	26.1	21.5	10.4

– Data not available

Table D

RELATIONSHIP BETWEEN OCCUPATION AND SMOKING, CANADA, 1986

	Occupational Category as a Percent of Total Occupations %			Percent Distribution of Smokers by Occupational Group %			Smoking Prevalence by Occupation %		
Profession	**Total**	**Males**	**Females**	**Total**	**Males**	**Females**	**Total**	**Males**	**Females**
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	28.2	30.7	25.8
MANAGERIAL	10.8	13.0	8.2	9.5	9.3	8.6	25.2	23.6	28.6
PROFESSIONAL	15.0	12.1	18.5	9.7	9.5	11.5	18.4	20.6	17.1
CLERICAL	16.7	5.8	30.0	17.1	16.8	31.6	30.2	33.0	29.5
SALES	9.7	9.2	10.2	8.9	8.7	10.4	27.1	25.8	28.6
SERVICE	15.3	11.3	20.2	17.3	16.9	24.4	33.2	32.2	33.9
OUTDOOR	5.0	6.9	2.6	4.5	4.7	2.2	27.0	28.1	23.4
MINING	5.9	8.8	2.3	8.0	7.8	3.3	40.2	40.4	39.4
FABRICATING	8.3	10.8	5.2	9.7	9.5	4.9	34.6	37.8	26.4
CONSTRUCTION	6.0	10.7	0.2	7.8	7.6	0.3	38.4	38.6	30.0
TRANSPORTATION	3.5	6.0	0.5	5.0	4.9	0.6	41.8	42.4	32.9
OTHER CRAFTS	3.8	5.2	2.1	4.4	4.3	2.3	37.0	38.6	38.5

A category entitled 'not working' was excluded from the list of occupational categories for the purpose of this table
The 'not-working' category includes respondents who never worked, are unable to work, and last worked more than five years ago.

Percentages may not add up to 100% due to rounding.

Table E

PREVALENCE OF REGULAR CIGARETTE SMOKING IN THE POPULATION 15 YEARS OF AGE AND OVER BY SEX, AGE AND MARITAL STATUS, CANADA, 1986

		TOTAL	MARRIED	SINGLE	OTHER
BOTH SEXES					
TOTAL	15 Years +	28.24	28.80	25.78	30.88
	15-19	17.57	50.11	16.59	12.88
	20-24	31.65	35.87	29.39	53.41
	25-44	33.40	31.97	33.02	48.29
	45-64	29.36	27.46	35.26	37.06
	65 Years +	14.44	14.84	16.12	13.46
	20 Years +	29.37	28.71	30.74	30.89
MALE					
TOTAL	15 Years +	30.79	31.61	26.94	40.43
	15-19	17.35	40.80	17.01	–
	20-24	31.33	37.92	29.61	15.31
	25-44	35.44	34.81	33.01	53.43
	45-64	33.59	32.11	40.43	42.38
	65 Years +	18.65	16.93	25.22	24.27
	20 Years +	32.27	31.59	31.85	40.51
FEMALE					
TOTAL	15 Years +	25.81	25.95	24.39	27.35
	15-19	17.79	53.57	16.14	39.80
	20-24	31.98	34.78	29.07	65.31
	25-44	31.39	29.20	33.04	45.66
	45-64	25.29	22.36	29.50	34.84
	65 Years +	11.26	12.00	10.79	10.69
	20 Years +	26.62	25.77	29.30	27.34

– Data not available

Table F

PERCENT DISTRIBUTION OF REGULAR CIGARETTE SMOKERS IN THE POPULATION 15 YEARS AND OVER BY SEX, AGE GROUP AND NUMBER OF CIGARETTES SMOKED PER DAY, CANADA, 1986

		AGE GROUP					
	TOTAL	15 Years +	15-19	20-24	25-44	45-64	65 Years +
BOTH SEXES							
Total Regular Smokers	5 562 424	329 164	708 664	2 729 367	1 427 294	367 935	
	%	%	%	%	%	%	
1-10 Cigarettes Per Day	20.4	40.7	22.8	16.7	19.1	29.7	
11-25 Cigarettes Per Day	67.3	57.1	73.5	68.7	65.8	59.8	
Over 25 Cigarettes Per Day	12.3	2.2	3.8	14.5	15.1	10.4	
MALE							
Total Regular Smokers	2 962 821	166 254	353 938	1 436 896	801 422	204 310	
	%	%	%	%	%	%	
1-10 Cigarettes Per Day	15.7	39.8	19.3	12.4	12.8	24.2	
11-25 Cigarettes Per Day	69.0	58.6	76.7	70.2	67.2	62.2	
Over 25 Cigarettes Per Day	15.3	1.6	4.0	17.3	20.0	13.6	
FEMALE							
Total Regular Smokers	2 599 603	162 910	354 726	1 292 471	625 872	163 625	
	%	%	%	%	%	%	
1-10 Cigarettes Per Day	25.7	41.6	26.2	21.5	27.2	36.7	
11-25 Cigarettes Per Day	65.4	55.5	70.2	67.0	64.0	56.9	
Over 25 Cigarettes Per Day	8.9	2.9	3.6	11.4	8.8	6.4	

Table G

PERCENT DISTRIBUTION OF REGULAR CIGARETTE SMOKING IN THE POPULATION 15 YEARS AND OVER BY NUMBER OF CIGARETTES SMOKED PER DAY, BY SEX AND REGION, CANADA, 1986

	REGION					
	TOTAL	ATLANTIC	QUEBEC	ONTARIO	PRAIRIES	BRITISH COLUMBIA
BOTH SEXES						
Total Regular Smokers	5 562 424	530 454	1 742 245	1 857 306	939 297	493 122
	%	%	%	%	%	%
1-10 Cigarettes Per Day	20.4	21.0	20.3	21.7	18.4	19.1
11-25 Cigarettes Per Day	67.3	65.2	66.5	67.9	71.3	62.4
Over 25 Cigarettes Per day	12.3	13.8	13.2	10.4	10.4	18.5
MALE						
Total Regular Smokers	2 962 821	285 584	927 112	980 646	504 425	265 055
	%	%	%	%	%	%
1-10 Cigarettes Per Day	15.7	17.2	15.2	16.3	15.0	14.6
11-25 Cigarettes Per Day	69.0	64.9	69.2	70.3	71.7	62.6
Over 25 Cigarettes Per day	15.3	17.9	15.6	13.4	13.3	22.7
FEMALE						
Total Regular Smokers	2 599 603	244 603	815 133	876 660	434 873	228 068
	%	%	%	%	%	%
1-10 Cigarettes Per Day	25.7	25.3	26.1	27.7	22.3	24.3
11-25 Cigarettes Per Day	65.4	65.5	63.5	65.2	70.8	62.2
Over 25 Cigarettes Per day	8.9	9.2	10.4	7.1	6.9	13.5

Table H

PERCENT DISTRIBUTION OF REGULAR CIGARETTE SMOKERS IN THE POPULATION 15 YEARS AND OVER BY NUMBER OF CIGARETTES SMOKED PER DAY, BY SEX AND EDUCATION, CANADA, 1986

		EDUCATION				
	Total	0 to 8 Years	Some Secondary And No Post-Secondary	Some Post-Secondary	Post-secondary Certificate or Diploma	University Degree
BOTH SEXES						
Total Regular Smokers	5 562 424	1 138 677	3 087 324	438 753	593 824	303 846
	%	%	%	%	%	%
1-10 Cigarettes Per Day	20.4	19.8	20.1	20.9	23.5	18.8
11-25 Cigarettes Per Day	67.3	65.2	68.6	67.5	65.4	64.7
Over 25 Cigarettes Per Day	12.3	15.0	11.3	11.6	11.1	16.5
MALE						
Total Regular Smokers	2 962 821	689 910	1 535 137	212 310	315 636	209 828
	%	%	%	%	%	%
1-10 Cigarettes Per Day	15.7	16.4	15.6	17.4	14.4	14.0
11-25 Cigarettes Per Day	69.0	66.1	70.4	68.7	70.9	65.4
Over 25 Cigarettes Per Day	15.3	17.5	13.9	13.9	14.7	20.7
FEMALE						
Total Regular Smokers	2 599 603	448 767	1 552 187	226 443	278 188	94 018
	%	%	%	%	%	%
1-10 Cigarettes Per Day	25.7	24.9	24.5	24.2	33.9	29.6
11-25 Cigarettes Per Day	65.4	64.0	66.9	66.4	59.1	63.3
Over 25 Cigarettes Per Day	8.9	11.1	8.6	9.4	7.0	7.1

Table I

PERCENTAGE REGULAR CIGARETTE SMOKING IN THE POPULATION 15 YEARS AND OVER BY AGE AND SEX, CANADA, 1966 TO 1986

		% REGULAR CIGARETTE SMOKER							
		1966 %	1970 %	1972 %	1977 %	1979 %	1981 %	1983 %	1986 %
BOTH SEXES									
TOTAL	15 Years +	42.8	40.6	39.8	35.9	34.2	32.7	31.1	28.2
	15-19	27.6	30.6	31.7	26.8	26.4	23.1	20.3	17.6
	20-24	51.7	47.7	47.3	43.0	41.1	40.4	37.3	31.7
	25-44	46.7	47.7	46.1	41.8	40.0	38.0	36.4	33.4
	45-64	44.8	41.2	40.6	36.3	34.5	33.7	31.6	29.4
	65 Years +	19.5	20.1	19.3	18.8	16.7	15.3	16.4	14.4
	20 Years +	45.3	42.2	43.3	37.3	35.4	34.0	32.4	29.4
MALE									
TOTAL	15 Years +	53.6	48.9	47.4	40.8	38.6	36.7	34.0	30.8
	15-19	35.1	35.7	35.0	26.9	26.8	22.8	20.3	17.4
	20-24	60.1	52.9	52.6	45.2	42.3	39.9	37.3	31.3
	25-44	61.8	55.5	53.3	47.0	44.0	42.6	39.0	35.4
	45-64	57.8	51.3	50.0	42.3	40.5	39.3	35.6	33.6
	65 Years +	32.3	31.4	30.4	27.5	24.6	21.3	22.1	18.6
	20 Years +	56.7	51.1	49.5	43.0	40.4	38.7	35.7	32.3
FEMALE									
TOTAL	15 Years +	32.1	32.4	32.4	31.1	30.1	28.9	28.3	25.8
	15-19	20.0	24.9	28.4	26.7	26.0	23.4	20.3	17.8
	20-24	43.4	41.4	40.6	40.7	39.8	40.8	37.3	32.0
	25-44	31.4	40.0	38.8	36.6	36.0	33.4	33.9	31.4
	45-64	31.7	31.5	31.6	30.5	28.9	28.5	27.8	25.3
	65 Years +	8.3	10.5	10.4	12.0	10.6	10.8	12.1	11.3
	20 Years +	34.0	33.6	33.0	31.8	30.7	29.6	29.3	26.6

Table J

PERCENTAGE DISTRIBUTION OF REGULAR CIGARETTE SMOKERS BY GROUPED NUMBER OF CIGARETTES SMOKED PER DAY BY SEX AND AGE, CANADA, 1966 TO 1986

	CIGARETTES SMOKED PER DAY											
	1 - 10				11 - 25				OVER 25			
AGE/SEX	1966	1970	1981	1986	1966	1970	1981	1986	1966	1970	1981	1986
BOTH SEXES												
TOTAL 15 Years +	26.9	24.6	19.7	20.4-	65.0	65.8	67.8	67.3	8.2	9.6	12.5	12.3
15-19	49.3	48.2	37.8	40.7	47.8	49.2	59.5	57.1	2.6	2.3	2.7	2.2
20-24	27.5	24.3	20.7	22.8	67.6	69.4	72.4	73.5	5.1	6.3	6.9	3.8
25-44	22.1	18.7	15.7	16.7	68.9	70.2	69.3	68.7	9.1	11.1	15.0	14.5
45-64	24.9	22.3	17.3	19.1	65.0	65.8	66.8	65.8	10.1	11.9	15.9	15.1
65 Years +	40.5	36.8	32.4	29.7	53.5	67.8	60.9	59.8	6.5	7.5	6.7	10.4
MALE												
TOTAL 15 Years +	21.4	20.3	17.6	15.7	68.1	67.5	67.3	69.0	10.6	12.2	15.1	15.3
15-19	46.9	45.7	40.4	39.8	49.4	52.1	56.1	58.6	3.7	2.2	3.5	1.6
20-24	20.5	20.8	19.9	19.3	73.1	71.6	72.8	76.7	6.4	7.6	7.3	4.0
25-44	15.5	13.3	13.5	12.4	72.6	72.4	68.6	70.2	11.9	14.4	17.9	17.3
45-64	19.0	17.7	15.0	12.8	67.7	66.7	65.6	67.2	13.3	15.8	19.4	20.0
65 Years +	37.8	33.4	25.6	24.2	55.1	56.7	66.0	62.2	7.4	9.6	8.4	13.6
FEMALE												
TOTAL 15 Years +	36.5	31.2	22.3	25.7	59.6	63.2	68.5	65.4	4.2	5.6	9.2	8.9
15-19	54.5	53.0	35.1	41.6	42.2	45.4	63.0	55.5	3.3	1.6	1.9	2.9
20-24	38.0	29.0	21.4	26.2	59.3	66.4	72.0	70.2	2.7	4.8	6.6	3.6
25-44	32.1	26.3	18.5	21.5	63.0	67.0	70.1	67.0	4.7	6.8	11.4	11.4
45-64	36.3	29.8	20.4	27.2	59.7	64.1	68.3	64.0	4.0	6.0	11.3	8.8
65 Years +	49.4	46.7	42.6	36.7	48.3	51.4	53.2	56.9	2.3	1.9	4.2	6.4

Table K

**PRESENT CIGARETTE SMOKING STATUS
BY AGE, SEX AND ETHNIC GROUP
N.W.T. – HEALTH PROMOTION SURVEY, 1985**

	YES	NO
TOTAL	49.62	50.38
MALE	49.40	50.60
FEMALE	49.87	50.13
MALE		
Total 15 YEARS AND OVER	49.40	50.60
15-19	41.24	58.76
20-24	68.92	31.08
25-44	48.15	51.85
45-64	38.63	61.37
65 YEARS AND OVER	63.51	36.49
FEMALE		
Total 15 YEARS AND OVER	49.87	50.13
15-19	56.36	43.64
20-24	60.99	39.01
25-44	45.58	54.42
45-64	47.45	52.55
65 YEARS AND OVER	37.19	62.81
INUIT		
Total	76.00	24.00
MALE	73.67	26.33
FEMALE	78.62	21.38
AGE GROUPS UNDER 30 YEARS	75.23	24.77
30 YEARS AND OVER	77.13	22.87
DENE		
TOTAL	62.02	37.98
MALE	57.80	42.20
FEMALE	66.18	33.82
AGE GROUPS UNDER 30 YEARS	65.66	34.34
30 YEARS AND OVER	58.10	41.90
NON-NATIVE		
TOTAL	39.87	60.13
MALE	42.19	57.81
FEMALE	37.23	62.77
AGE GROUPS UNDER 30 YEARS	44.39	55.61
30 YEARS AND OVER	36.69	63.31

Table L

PREVALENCE OF REGULAR CIGARETTE SMOKING BY EMPLOYMENT STATUS BY AGE AND SEX LABOUR FORCE SMOKING SURVEY, 1986

	EMPLOYED	UNEMPLOYED	NOT IN LABOUR FORCE
BOTH SEXES			
Total 15 YEARS AND OVER	29.96	41.39	23.23
15-19	20.87	33.04	12.29
20-24	30.44	43.92	29.36
25-44	32.04	45.97	34.96
45-54	31.43	34.04	33.31
55-64	23.41	35.35	28.29
65 YEARS AND OVER	13.22	–	14.55
MALE			
Total 15 YEARS AND OVER	31.70	42.24	24.85
15-19	20.30	32.29	11.50
20-24	31.84	44.38	19.97
25-44	33.68	48.35	47.16
45-54	35.07	29.23	47.13
55-64	25.27	43.27	39.03
65 YEARS AND OVER	16.21	–	19.03
FEMALE			
Total 15 YEARS AND OVER	27.65	40.11	22.41
15-19	21.45	34.48	13.04
20-24	28.93	43.24	36.06
25-44	29.95	42.77	32.70
45-54	25.98	41.06	30.26
55-64	19.87	20.60	23.10
65 YEARS AND OVER	4.41	–	11.48

– Data not available

Appendix B

Disease Control Agencies and Resources

■ ■ ■

1. Canadian Cancer Society
   130 Bloor Street West, Suite 1001
   Toronto, Ontario
   M5S 2V1
   (416) 961-7223

2. Canadian Heart Foundation
   Suite 1200, 1 Nicholas Street
   Ottawa, Ontario
   K1N 7B7
   (613) 237-4361

3. Canadian Lung Association
   75 Albert Street, Suite 908
   Ottawa, Ontario
   K1P 5E7
   (613) 237-1208

4. Canadian Council on Smoking and Health
   725 Churchill Avenue
   Ottawa, Ontario
   K1Z 5G7
   (613) 722-3419

   (Contacts in each province)

5. London/Middlesex Lung Association
   480 Egerton Street
   London, Ontario
   (519) 679-8160

Appendix C

Women's Cessation Programs

1. Smokefree
   183 Munro Street
   Toronto, Ontario
   M4M 2B8
   (416) 465-1323

2. Manitoba Lung Association (Brandon)
   42 McTavish Avenue East
   Brandon, Manitoba
   R7A 2B2
   (204) 725-4230

Appendix D

Anglophone Women's Health Groups

Newfoundland

1. Planned Parenthood
   203 Merrymeeting Road
   St. Johns, Newfoundland
   A1C 2W6
   (709) 579-1009

Prince Edward Island

2. Women's Network
   P.O. Box 2333
   Charlottetown, P.E.I.
   C1A 7K4
   (902) 894-8027

3. East Prince Women's Information Centre
   204 Water Street
   Summerside, P.E.I.
   C1N 1B3
   (902) 436-9856

New Brunswick

4. New Brunswick Advisory Council on the Status of Women
   95 Foundry Street, #207
   Moncton, N.B.
   E1C 5H7
   (506) 853-1088

5. Support for Single Mothers
   154 Queen Street
   Moncton, N.B.
   E1C 1K8
   (506) 858-1303

Nova Scotia

6. Antigonish Women's Resource Centre
   256 Main Street
   Antigonish, Nova Scotia
   B2G 2C2
   (902) 863-6221

7. Truro Women's Resource Centre
   64 Inglis Street
   Truro, Nova Scotia
   B2N 4B4
   (902) 893-8914

8. Women's Action Coalition
   84 Grandview Street
   Sidney, Nova Scotia
   B1P 3N6
   (902) 564-7833

9. Women, Health and Medicine/(WHAM)
   Women's Health Education Network (WHEN)
   Box 2, Sir Charles Tupper Medical Building
   Dalhousie University
   Halifax, Nova Scotia
   E3H 4H7
   (902) 426-2700

10. Picton County Women's Group
    Box 964
    New Glasgow, Nova Scotia
    B2H 5K7
    (902) 752-8897

Ontario

11. Northwestern Women's Health Information Network
    c/o 341 Claret Street
    Thunder Bay, Ontario
    P7A 2M7
    (807) 345-1410

12. Ontario Public Interest and Research Group
    1 Trent Lane
    University of Guelph
    Guelph, Ontario
    N1G 2W1
    (519) 824-2091

13. Women Healthsharing
    200A – 101 Niagara Street
    Toronto, Ontario
    M5V 1C3
    (416) 862-1791

14. Women Today
P.O. Box 1405
Clinton, Ontario
N0M 1L0
(519) 428-9706

Manitoba

15. Consulting Committee on the Status of Women with Disabilities
924 – 294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9
(204) 942-3604

16. Gate Keepers Health Project
301 – 83 Churchill Drive
Thompson, Manitoba
R8N 0L6
(204) l778-8713

17. North End Women's Centre
453 Selkirk Avenue
Winnipeg, Manitoba
R2W 2M4
(204) 589-7347

18. Winnipeg Women's Health Clinic
419 Graham Avenue, 3rd Floor
Winnipeg, Manitoba
R3C 0L8
(204) 947-1517

19. Women's Health Interaction Manitoba
60 Maryland Street, 2nd Floor
Winnipeg, Manitoba
R3G 1K7
(204) 786-2106

Saskatchewan

20. Common Cause Crocus Co-op
211 5th Avenue North
Saskatoon, Saskatchewan
S7K 2P0
(306) 653-4620

21. Regina Healthsharing
Box 734
Regina, Saskatchewan
S4P 3A8
(306) 352-1540

Alberta

22. Athabasca University
Woman's Studies
Athabasca, Alberta
(403) 675-6111

23. Boyle St. Community Services Co-op
9720 102 Avenue
Edmonton, Alberta
T5J 0E3
(403) 424-4106

24. Edmonton Women's Health Collective
Box 4134
Edmonton, Alberta
T6E 4T2

25. Grace Hospital Women's Health Centre
1402 8th Avenue
Calgary, Alberta
T2N 1B9
(403) 284-1141

British Columbia

26. Victoria Status of Women Action Group
620 View Street, #320
Victoria, B.C.
V8W 1J6
(604) 381-1012

27. Victoria Alcohol and Drug Programmes
228 – 9801 Quadra Street
Victoria, B.C.
V8W 2K7
(604) 387-5077

28. Vancouver Women's Health Collective
888 Burrard Street
Vancouver, B.C.
V6Z 1X9
(604) 682-1633

29. Chetwynd Women's Resource Society
P.O. Box 72
Chetwynd, B.C.
V0C 1J0
(604) 788-3793

Appendix E

Quebec Women's Groups and Disease Control Agencies

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1. Centre des femmes de Verdun
   3993 Wellington Street
   Verdun, Quebec
   H4G 1V6
   (514) 767-0384

2. Centre de santé des femmes du quartier
   16 Saint-Joseph Street E.
   Montreal, Quebec
   H2T 1G8
   (514) 842-8903

3. Council on Smoking and Health
   c/o Lung Association
   1173 Charest Street W., #204
   Quebec, Quebec
   G1N 2C9
   (418) 243-2020

4. Dept. santé communautaire
   1000 Sainte-Anne Street
   Joliette, Quebec
   J6E 6J2
   (514) 759-9900

5. Fédération du Québec pour le planning de naissance
   3826 Saint-Hubert Street
   Montreal, Quebec
   H2L 4A5
   (514) 842-9501

6. Heart Foundation
   440 Dorchester Street W., #1401
   Montreal, Quebec
   H2Z 1V7
   (514) 871-1551

7. Cité de la Santé Laval
   1755 René-Leannec Street
   Laval, Quebec
   H7M 3L9
   (514) 668-1010

8. Quebec Cancer Society
   P.O. Box 183
   Place Bonaventure
   Montreal, Quebec
   H5A 1H8
   (514) 861-9227

9. Quebec Non-Smokers Association
   Mascouche Heights, Quebec
   J7L 2C6
   (514) 477-9304

10. Laval University
    Dept. of Anthropology
    Room 6407, De Koninck Bldg.
    P.O. Box 2208
    Ste-Foy, Quebec
    G1K 7P4
    (418) 656-2131 (General #)